Mapping the market II Commissioning support services

Cogora

NHS England

Contents

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Foreword

In June 2013, NHS England published its strategy for developing commissioning support services. Its aim is to ensure that every commissioner has access to excellent affordable support which enables them, in turn, to secure the best outcomes for patients and value for taxpayers. Since then we have made substantial progress with implementation:

> Supporting clinical commissioning groups (CCGs) to become confident informed customers of commissioning support – through a 'choice app' listing providers, the first 'Mapping the Market' report and a 'make/share/buy toolkit'.

> Developing a more diverse cohort of high quality providers of commissioning support – supporting the development of NHS Commissioning Support Units (CSUs); encouraging them to partner with other CSUs, commercial and voluntary organisations; agreeing the organisational forms in which CSUs can become autonomous by 2016.

> Establishing simple, effective procurement mechanisms for commissioning support – the lead provider call-off framework (which has just been launched via the Official Journal of the European Communities) and, in parallel, starting to develop a list of specialist and niche providers, which should help to enable participation by small to medium enterprise (SMEs) and voluntary sector organisations (VSOs). This, in parallel with initiatives such as the 'Compact' between the NHS CSU Network and the Association of Chief Executives of Voluntary Organisations, the recent Nuffield report Role of the voluntary sector in providing commissioning support, Mapping the Market, and broader awareness-raising should help commissioners gain access to the valuable support which VSOs and SMEs can offer, including deep subject matter expertise, achieving the very best outcomes for specific patient conditions and accessing knowledge that has been built over years of research or entrepreneurial activity based on system needs.

I am delighted that this seems to be bearing results. We are seeing significant teaming up between CSUs and VSOs, where informal conversations are becoming formalised partnerships and VSOs are developing strong offers for the commissioning support market. Examples we've encountered include:

> NHS South West CSU and Marie Curie have a long standing agreement that allows for each to bring the best of their respective skills to bear where this will achieve the optimal outcome for patients and CCGs, yet respects the need for both organisations to work independently too. (Such an arrangement based on sharing knowledge and expertise clearly encapsulates the essence of partnership working).

> Arden CSU has been working with the Young Foundation to develop a model of social entrepreneurship. Seven local community based initiatives have received business support and mentoring to develop sustainable service offers that address CCG development priorities for health improvement. These include frequent GP attenders, obesity and rural isolation.

> Papworth Trust reached out to Greater East Midlands CSU to learn more about the commissioning process; together they have developed a mutually beneficial relationship and insight to each other's sector which is already leading to new support services being created for disabled people by Papworth Trust.

SMEs have been making significant inroads to working with CCGs, often collaboratively with other SME and independent sector organisations. They are also leading on conversations with CSUs and others targeting lead provider status, which indicates a developing and maturing supply chain. This report touches on only part of the deep knowledge, offers and expertise the VSO and SME market has to offer. To further develop the commissioning support market, we are currently redeveloping the choice app to better meet the needs of commissioners and suppliers, and will be holding cross sector commissioning support networking events, releasing plans for locally driven CSU autonomy consultations in addition to continuing to work and engage with the market to develop the lead provider call-off framework, which will enable commissioners to secure the best possible services as easily as possible.

Bob Ricketts
Director of Commissioning Support Services Strategy & Market Development NHS England

About this report

In the second part of *Mapping the Market*, which explores the contributions of voluntary sector organisations (VSOs) and small medium enterprises (SMEs) to commissioning support, 12 VSO representatives were interviewed about how they can support commissioners. A further combined total of 15 SMEs and VSOs sent information about their commissioning support offering via an online survey tool.

We questioned organisational representatives about the services they offer, their insights on the CSS market as well as any challenges and opportunities the market brings.

The aim of this research is to capture the movements of the emerging CS market. As well as serving as a directory for commissioners, it also offers an opportunity for CSS organisations to see how they can collaborate to provide the mix and blend of services that are increasing required.

About Cogora

Cogora is a leading, pan-European healthcare publishing and research company. For over 20 years we have enjoyed a first-rate reputation for delivering top quality, timely content that supports healthcare professionals with their clinical decision-making and career development.

Our portfolio of journals and websites includes *Nursing in Practice*, *Management in Practice*, *The Commissioning Review* and *Hospital Pharmacy Europe*. We deliver 12 national conference exhibitions – including Commissioning Live – each year, as well as more than 100 smaller educational 'road show' events across the UK. And we produce numerous 'roundtable' discussion meetings, focusing on a single therapeutic area, across Europe.

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Executive summary

As commissioners strive to meet multiple agendas and move towards whole-system integrated care pathways, the need for a dynamic and varied commissioning support service (CSS) market continues to grow.

Voluntary sector organisations (VSOs) and small medium sized enterprises (SMEs) are now joining commissioning support units (CSUs) and some of the more established independent sector providers in the emerging market to meet the need for specialised niche services.

It is clear that the voluntary sector have a lot to bring to the table with expertise on the most up-to-date treatments and services for their patient groups, excellent patient engagement services through the extended reach they have within the community and across stakeholders. Also invaluable is their large evidence-base of trialed and tested service delivery methods as well as business intelligence which both contextualises governmental sources of information and goes beyond the available information.

With the treatment of co-mordities and long-term conditions high on the commissioning agenda, many VSOs also talk of the potential that the collaborations within their own sector can bring.

Similarly, the SME sector show an ever increasing array of innovative CSSs including systems-based methods of data collection that can be accessed remotely by patients, variations of outcomes-based commissioning models, sophisticated financial modeling platforms that deal with invoice validation as well as multi-systems approaches to commissioning support going beyond health and social care boundaries to include the spiritual and psychological dimensions.

While very keen to provide an input, a common theme for both SMEs and VSOs is that the CSS market can be challenging to navigate. As well as current restructures causing difficulties in finding the right point of contact within commissioning bodies, thinking is still evolving around whether approaching CSUs or CCGs directly is the best course of action.

Furthermore, while patient advocacy and being able to have the services that patients and their carers say they need implemented is the mantra for VSOs, and offering advice freely has always been a means to an end, opportunities now arise for more formal recognition of their support as well as monetary contributions to their cause.

As the CSS market continues to take shape, offering both challenges and opportunities for providers, how organisations will orient themselves and collaborate to best suit the needs of commissioners remains to be seen.

Asthma UK

Commissioning support services

Interim director of nations, regions and services: Linda Edwards

1. How have you supported commissioners in the past, and what is your potential CSS offering?

As a small organisation one of the things we have been looking at is how we can deliver the most benefit for people with asthma and support as many commissioners as possible. We offer a range of support, and we are currently developing a suite of six tools that can save costs on a wide scale using a set of simple processes. These include increasing the uptake of written action plans developed by Asthma UK, which have been proven to reduce readmissions by around 64% and new admissions by 26% in a number of areas across the UK.

We've also demonstrated by our work with primary schools and early learning centres through initiatives such as the Ealing project that hospital readmissions can be reduced by 56%. This is achieved by maintaining an asthma register, making sure there is access to emergency inhalers, and identifying champions within schools to act as specialist advisors as well as helping to work with parents. The next stage was a GP practice-based training programme to ensure that practices are up-to-date with asthma care. We have the tools ready to roll out and a few CCGs and local authorities are already keen to pick it up and run with this approach.

Facts and figures

Number of dedicated staff in the healthcare team: 15
Current CCG, CSU and other NHS customers: Undisclosed
Percentage of income from NHS contracts: <1%
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Undisclosed
Service coverage/types of service provided: Policy influencing, patient information, commissioning support
Main competitors: Undisclosed

We've also invested in the development of an asthma dashboard which gives us a series of high level indicators looking at quality and cost based around hospital admissions and prescribing. We can then look at detailed indicators including patient views, prevalence, admissions and practice level variance. This is very helpful in identifying asthma 'hotspots' around the UK. Sixteen CCGs are currently signed up to our Compare Your Care programme, which allows them to access information about services in their local area and compare it to services and outcomes in other areas.

We can also help with planning, commissioning intentions and health needs assessments. Currently, we're working very closely with public health agencies in Wales, Scotland and Northern Ireland to look at their joint needs assessments, and we're looking to see how we can replicate this in England. Potentially, we could provide patient engagement services given enough resources.

Currently, we have a small team who work specifically with the asthma community and have experience with peer support. Scotland has been very good with funding in this respect—so we have learned a lot there that could be translated to the rest of the UK. We're also currently putting together a policy report about a medicines optimisation programme and are exploring ways to enable pharmacists to take a more active role in their local community.

2. How is your business structured? How does CSSs fit into this?

We have policy and research, services (including health promotion; clinical advice and support, and a nurse-run patient helpline), operations, fundraising, and marketing/communications. We're currently undertaking organisational shift to realign ourselves to influence policy and support commissioners more effectively. We have three national offices and a small English regions team. But it's a matrix approach, so if the regional teams are working on a project, they work with colleagues from other departments.

3. What is different about your organisation, and why should commissioning organisations come to you?

Asthma is one of the most prevalent conditions in the UK. More than 5.5 million people have asthma; it covers a wide demography from small children to the elderly, ranging from minor symptoms to those that are severe and debilitating.

We are the leading specialists in this area and have knowledge of what does or does not work. The benefits of working in a devolved organisation is that if something is working in one country, we can share the learning in other parts.

We have a long history of funding world class laboratory-based research , and are about to launch a centre for applied research. It's a virtual research facility with links to researchers all across the UK and administrative support in Edinburgh. The launch will coincide with World Asthma Day and the launch of the National Review of Asthma Deaths in May.

4. What is your policy regarding payment?

We're doing some more thinking around it before we come out and say one way or another. A policy will be developed in due course.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?

There's a huge shifting agenda facing them at the moment. CSSs can provide support by applying our understanding of the condition and undertaking some preliminary analysis for them. We can also provide a patient voice as we have access through a team of volunteers across the country. With our expertise and understanding of the condition, we can enable commissioners to secure better outcomes for patients by following some simple processes, such as asthma action plans, which for minimal investment can make a huge difference in terms of proven savings for commissioners.

6. What partnerships or planned partnerships do you have?
The Royal College of Physicians, the Department of Health for policy development, the Richmond group of charities. the Primary Care Respiratory Society and the British Lung Foundation. We can also look to undertake more specific projects with individual charities in key areas, focusing on a particular demographic.

7. What are the major challenges of working as a provider of CSSs?
Scale is one of our biggest challenges. We are a small organisation, but there are lots of commissioners we'd like to help, which is why we are developing models that can be applied widely. We receive very little corporate investment at the moment with our funds mainly coming from individuals, so we need to use money as effectively as possible.

8. How do you see the CSS market evolving?
It's very difficult to say – simply because there are several directions development could go, and I'm not sure that it will be the same across different parts of the country either. I think we will be faced with a different model for different parts of the country, so we're going to have to be pretty nimble and flexible in the way we can work with different organisations.

9. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?
It is something we are looking at. However, until now, we've been focused on getting the basics right so that we're absolutely clear about the level of support we can provide. Hence, our focus on influencing policy and development of toolkit/processes to demonstrate the impact of specific interventions.

Biography

How does your career so far help you in working with the NHS?
My background is NHS. I was a chief executive and regional director in primary and community-based care, and 15 years ago, I started to work more with the voluntary services sector and the wider health system. Before my current role, I worked for several hospices.

What attracted you to working in this area?
I'm passionate about healthcare, and I can see that there are multiple roles for voluntary services to challenge and support the existing healthcare systems to enable better outcomes for patients.

What do you enjoy doing outside of work?
Being outside—so gardening, walking the dog, swimming, running and cycling.

Alzheimer's Society

Commissioning support services

Operations director - Greater London: Kate Moore

1. How have you supported commissioners in the past, and what is your potential CSS offering?

We have provided support and care services for many years and so, historically, our local managers have worked with commissioning bodies, dementia boards and strategy groups, contributing quite actively and extensively to developing care pathways and commissioning priorities for all forms of dementia.

Although we often provide this information to commissioners as a precursor to our role as a service provider, we are also mindful of our role as a campaigning charity and so are keen to ensure commissioners are informed by what people affected by dementia tell us is important to them. Our own service specifications are evidence-based and outcomes-focused, looking at quality benefits rather than being driven by cost or profit.

One of the things we've been doing over the last two-three years is adding to our evidence-base by improving our involvement methods to ensure that we get the breadth of views of people at different stages of dementia. This includes the use of service user review panels which are formalised facilitated discussion around specific subjects, in addition to evaluations, surveys and non-verbal communication methods.

Facts and figures

Number of dedicated staff in the healthcare team: 300
Current CCG, CSU and other NHS customers: Undisclosed
Percentage of income from NHS contracts: Undisclosed
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Undisclosed
Service coverage/types of service provided: Information, support and care services for people with dementia, carers and families
Main competitors: Undisclosed

Primarily, we're developing this evidence base with the aim of informing our own activity, but by default, it can also serve to inform commissioning development.

We can also bring our experiences to support commissioners around decisions for services we may not be providing ourselves, but where dementia might be a feature. This could be in the context of other long-term conditions or co-morbidities in addition to dementia.

So, coming back to the question about a potential offering, I expect we will be looking at how we might formalise our commissioning support offer.

2. How is your business structured? How does CSSs fit into this?

The charity is involved in three key areas of activity including research into cause, cure and care, provision of support and care services and campaigning.

Within our service operations directorate, our management structure divides into regions, areas and localities throughout England, Wales and Northern Ireland. There are around 1800 staff contributing to operations, including the regional management structure and those in frontline service delivery.

The interface with commissioners currently sits with operations managers, who will be using relationships they've built locally across health and social care to advocate for the right support and services for people with dementia.

If we decide to go ahead more proactively with a formal commissioning support offer, we might need to consider how this is reflected structurally given our role as a service provider.

3. What is different about your organisation, and why should commissioning organisations come to you?

Our specialist knowledge and expertise in dementia has been built up over the last 35 years. We have researched and built evidence about what works for people affected by different dementias and at different stages in the condition. We have good access to people with dementia and so can involve them in finding out what they need and bring co-production methods to our service development. Increasingly, we're working with more diverse groups and communities to ensure that, for example, people from different ethnic groups and cultures can be appropriately supported.

Additionally, we have examples of working very closely with statutory partners and bringing our evidence base and experience to developing a whole-system care pathway that then results in co-ordinated and integrated commissioning activity and service provision.

4. What is your policy regarding payment?

The formalisation of a commissioning support market brings with it considerations and also opportunities. In the past, we've helped advise commissioners as part of our charitable offering with the end goal being appropriate services for people with dementia.

If there are now funds for commissioning support, it offers an opportunity for a formal route for ensuring that commissioning is well informed and is a systematic way for us to bring our knowledge and intelligence into that. However, if private sector organisations are charging for this activity, and we are offering it on a charitable basis, that produces all sorts of different thinking which needs to be explored.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?

I expect the big challenge is trying to commission as much as they would like with the funds they actually have. Local authorities are very challenged with funding currently and they are under pressure from many different organisations, representing different conditions. NHS commissioners within the developing CCGs need to identify priorities, establish how best to co-ordinate their commissioning activity and ensure they achieve the most needed outcomes.

They are also required to consult with patients and service users and that's an area where we can support them to consult effectively with people with dementia. Furthermore, we have already done much

work to evidence what support and services work well and we have ongoing programmes of evaluation and improvement.

6. What partnerships or planned partnerships do you have?
We work both nationally and locally with a large number of voluntary organisations, professional membership organisations and statutory bodies. We were an initiating founder of the National Dementia Action Alliance, which brings together all organisations that have an interest in improving the lives of people with dementia. As a service provider, we also have different arrangements across the countries; some formal partnerships through service contracts and many other informal through local voluntary and statutory sector networks.

7. What are the major challenges of working as a provider of CSSs?
When it comes to CSS contractual agreements, we will need to consider how to separate our service provider work with CSS services so we're clear about any conflicts of interest. We'd be looking internally at how we package those two things to bring clarity for ourselves and for those we would be working with.

Another challenge is that currently the developing NHS commissioning environment is still in a state of flux. If we're to engage and to bring meaningful support to that, we have to develop a clear understanding of who's doing what and where – and what they need from us. Whenever there's national restructuring, the voluntary sector try to keep up with who's responsible for what, and where you need to build relationships. This of course puts pressure on our resources.

8. How do you see the CSS market evolving?
This could be an opportunity to improve and bring greater equity to the relationship between statutory agencies and voluntary sector organisations. Supporting commissioning planning has been a default position for many voluntary sector organisations for many years and given freely. We have tended to respond readily with our expertise because of our commitment to achieving needed services for people with dementia. If a commissioning support market allows us to move into a relationship where our support is acknowledged formally, that would be positive, bringing greater security to the charity and an improved, more sustainable level of service.

9. Do you have plans to enter into partnership arrangements with potential lead providers of CSS?
We need to agree formally whether that's a route we'd like to take, but we're always open to partnership arrangements. We would look at the fit with our current five year strategy and business plans and, if we felt this was a significant strategic step for the charity, we'd engage our board of trustees in coming to a decision.

Biography

How does your career so far help you in working with the NHS?
I've worked in the voluntary sector for about 20 years, specialising always in health and social care, and I have a lot of experience delivering services for older people. I've been with the Alzheimer's Society for nearly eight years. I've also been active at a local level, managing a community and voluntary service in Sussex and providing a liaison function with the statutory agencies and commissioners. I worked at Age Concern England prior to my current role.

What attracted you to working in this area?
Working often with older people, I've had frequent contact with people who have been affected deeply by dementia. Also, my husband's mother died with Alzheimer's Disease and was entirely supported by my late father-in-law. All this has had an impact on me, made me see how challenging dementia can be and want to improve things for those affected. Also, I've always wanted to work in the voluntary sector as it supports my values and enables improvement and change.

What do you enjoy doing outside of work?
For me, free time is a lot about family, walking, gardening and growing vegetables particularly! I also enjoy music, singing regularly with a local choir.

British Heart Foundation

Commissioning support services

Commissioning support lead currently unspecified

1. How have you supported commissioners in the past, and what is your potential CSS offering?

We have funded innovative pilot projects in the NHS since 1996 to develop best practice evidence of improved outcomes and patient experience. We have been supporting commissioners for many years, but it has been more formalised in the last year since joining the Department of Health commissioning support mentoring scheme.

Our pilot work has included identifying gaps in service provision analysing health needs assessments including joint strategic needs assessments (JSNAs), helping clinical commissioning groups (CCGs) benchmark their services against (NICE) National Institute for Clinical Excellence clinical guidance.

Part of our core offer is supporting redesign, and this is informed by the body of evidence we've built up working with NHS Trusts to trial new ways of delivering care via our innovation programme, which have been externally evaluated through academic institutions and in some cases validated through the quality innovation productivity and prevention (QIPP) process. An example is the implementation of Arrythmia care co-ordinators to streamline management, which led to savings of £2,000 per patient seen by a specialist nurse and from prevention of hospital episodes.

The requests we've been responding to in redesign vary from looking at a CCG's whole portfolio around cardio vascular care to more specific input, such as in Leeds, where we've been working around restructuring the palliative care pathway to better incorporate patients with heart failure. This has been informed by a project in Glasgow developed in partnership with Marie Curie Cancer Care and Greater Glasgow & Clyde HB identifying appropriate models of palliative care for end stage heart failure (HF) patients, which can be complicated due to the unpredictable trajectory of end stage heart failure.

We also help with business intelligence, cross referencing NHS England data with disease profiles, and supplementing it with our own data produced by the BHF Oxford Public Health Research Unit. Additionally, we help commissioners to use tools that are already available such as the NHS England's Commissioning for Value Insight Packs, which show how data at a regional and local level can provide great insight on where savings can be generated and improvements in patient experience and outcomes can be made.

We're also launching an online business case toolkit which will help local teams to develop business cases by helping them to populate the national policy context, working out which outcomes framework indices to use, identifying local data to make the business case, calculating the cost savings that result from pathways and defining evaluation methods.

Another significant tranche of our work is our patient insight, engagement and user involvement activity. We have local heart support groups and individuals who we can link with CCGs to inform their planning from the beginning all the way through to the development of a pathway.

Facts and figures

Number of dedicated staff in the healthcare team: 23 (regional service development team)
Current CCG, CSU and other NHS: For our CS pilot scheme: 9 Clinical Commissioning Groups, 7 Strategic Clinical Networks, 5 Commissioning Support Units, 2 Clinical Senates, 1 Academic Health Science Network
Percentage of income from NHS contracts: Non applicable
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Non applicable
Service coverage/types of service provided: Support and advocacy; policy influencing; research; CSS as question 1
Main competitors: Undisclosed

2. How is your business structured? How does CSSs fit into this?

We have a business development team who develops the data to support our regional teams. We have teams in the four nations working on policy at a national level, including regional service development teams that work with local Trusts and commissioners. Resources may be secured from different teams across the organisation to inform specific projects. For example, members from the healthcare & innovation team share the evidence base with regional teams so that they can better advise CCGs and strategic clinical networks on service redesign.

3. What is different about your organisation, and why should commissioning organisations come to you?

We have an excellent reputation for developing services with the patient at the centre of our work. We have a longstanding reputation as well as experience with modeling service redesign and having them evaluated.

Our projects are independently and robustly evaluated by academic institutions. To date, we have been successful in achieving additional validation with two projects submitted to QIPP and published on the NHS Evidence website. It is crucial that commissioners commission evidenced-based models of care, and it would be a brave commissioner to try out something untested.

This is even more important given that the NHS may not necessarily have the resources to spend on trialing or evaluating new service delivery methods, which can often mean limitations to how closely providers adhere to the NICE guidance and other recommended frameworks. Some of the work we've done with CCGs and strategic clinical networks, to reframe their commissioning intentions, has led to substantial cost savings.

We also have a good reach to patients and carers as well as established relationships with some of the larger acute trusts we worked with to pilot redesigns. As a research driven organisation, it is critical that our work

is validated and meets strict criteria. We were also a key player in contributing to the NHS England Cardio-Vascular Disease Outcomes Strategy. The BHF is not a contracted service provider, therefore there is no vested interest in who is delivering which services. Our priority is to embed evidence-based, best practice at scale and pace to inform quality care, helping us to provide impartial and objective commissioning support.

4. What is your policy regarding payment?
We want the best outcomes for patients and have a long history of developing innovative, effective models of care, sharing best practice and helping to design new pathways. We know that commercial organisations are attaching a market value to commissioning support and that is something that we, like many other charities, need to consider to allow us to provide a national commissioning support service.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?
The greatest challenge for NHS commissioners is delivering service redesign within the current financial constraints. The extensive portfolio of work demands an innovative approach to improving the patient experience and outcomes, and ensuring that the care delivered is appropriate and accessible for the patient. The voluntary sector needs to be more active in promoting what they can offer the commissioners including not least the patient voice but also significant experience in service redesign and management of co-morbidities. Charities are exploring ways of working together to address the long-term conditions agenda and ensuring patients with co-morbidities receive care, which is aligned to their need.

6. What partnerships or planned partnerships do you have? Who does your network include?
We've collaborated with a range of charities in the past including Heart UK , Marie Curie, Macmillan, Diabetes UK and we are a member of the Richmond Group of charities. We also have a lot of influence at the four nation level and link with Public Health England. With the agenda being very much about managing long-term conditions, we're already having discussions with charities specialising in similar co-morbidities such as diabetes and respiratory diseases about whether we need to co-align for commissioning support to avoid overlaps. In the next few months, we'll probably be engaging more with strategic networks because that's probably where we're going to have the most impact, and we will reach CCGs through them.

Biography

The British Heart Foundation is in the process of formalising a commissioning support offer so cannot as yet provide details of a lead contact.

7. What are the major challenges of working as a provider of CSSs?
We're still in the pilot phase of providing commissioning support, so on the one hand we need to firm up our support and think about developing our team as well as reprioritising our work to support the commissioning agenda. On the other hand, there's the challenge of pitching our support at the right level, so whether that's on a regional level, with individual CCGS or with commissioning support partners.

We recognise that it would be very challenging to support all 211 CCGs individually, so we are exploring which engagement mechanisms within the new commissioning structures will have the most influence and impact.

There's also a communication challenge for VSOs to let commissioners know about our commissioning support offers once it is formalised, as currently, a lot of commissioners have told us they don't know they can approach us for support. We need to develop a proactive marketing approach similar to commissioning support units.

8. How do you see the CSS market evolving?
VSOs are well placed to provide this service, however the challenge is resource capacity. To address this challenge we need to consider a robust financial model to allow us to support this work in the longer term.

I anticipate that a number of charities will be considering how to develop this area of work as the benefits of working with and directly influencing services for patients is key to improving patient experience and outcomes.

9. Do you have plans to enter into partnership arrangements with potential Lead Providers of CSS?
We have had conversations with commissioning support units (CSUs) where they've seemed very keen to work with us, especially to secure input on service redesign. Ideally, we'd like to follow the model the Macmillan in Staffordshire of working with 10 CCGs across the patch and influencing long-term, commissioning intentions at scale.

Simon Gillespie, Chief Executive BHF: "The true impact of charities such as BHF engaging with CCGs, clinical networks and CSUs can be, and should be, assisting longer-term sustainability and consistency of high quality, evidence-based interventions at scale that make real and positive differences to patients' lives"

Cancer Research UK

Commissioning support services

Primary care engagement programme lead; Elizabeth Bates

1. How have you supported commissioners in the past, and what is your potential CSS offering?

One of our longest standing programmes is our unique cancer statistics and intelligence service which provides interpretation and information on all cancers. More recently, we have been helping clinical commissioning (CCGs) and strategic clinical networks (SCNs) in Merseyside and Cheshire, and North East/ Central London to engage with primary care specifically around earlier diagnosis of cancer.

This involves experienced, non-clinical facilitators talking to practices about their cancer profiles, showing them the resources and tools available and getting them to agree to an action plan. It's been very well received and is increasingly considered a form of commissioning support. It also serves as a form of business intelligence as we have a good overview of what's happening across practices and can provide feedback to CCGs on commissioning issues to prompt further investigation if necessary.

Although we started off working with GP practices, our facilitators are increasingly spending time with commissioners to help develop their cancer commissioning intentions and exploring ways to move forward with early diagnosis, referral pathways and prevention. For example, in London, we are working with all CCGs and the NHS transforming cancer services team to develop a pan-London five-year commissioning strategy for cancer.

Our facilitators also run cancer summits where practices, CCGs, providers and clinicians across primary and secondary care are brought together to share best practice. We also support the development of strategic clinical networks, helping to advise on evidence-base for early diagnosis and provide practical support through our bridging fund

We inform the process by using our own cancer statistics as well as adding intelligence to data provided by Public Health England, the NHS cancer commissioning tool-kit and other government sources. Our Cancer Intelligence Portal www.cruk.org/localstats also allows CCGs or local authorities to access local data which is presented using user friendly infographics accompanied by tailored intelligence statements including the statistical significance, our policy and advocacy position and suggestions on ways to move forward. We have used this data to help CCGs engage with the public, CSUs to engage with CCGs and CCGs to engage with trusts if they're having conversations about service configuration. This service has been piloted with London Cancer and Merseyside and Cheshire CSU.

2. How is your business structured? How does CSSs fit into this?

Our policy and information directorate work closely with the NHS. There are six key areas of work within that directorate: policy, evidence and intelligence, early diagnosis, local engagement and influencing, and patient engagement and tobacco control.

We also have an excellent health marketing team who have done some innovative work looking at how media can influence patients to see their GP. We would draw resources across all these functions to deliver commissioning support.

3. What is different about your organisation, and why should commissioning organisations come to you?

We are the largest charitable funder of cancer research in the world, funding research on all types of cancer, so our knowledge of this complex set of diseases is second to none. We provide information and intelligence on prevention, screening and early diagnosis across the patient pathway to treatment and beyond, all of which is available on our website.

Being a research organisation, we have an evidence-based and robust approach, evaluating everything we do. Interpreting and providing context to cancer registry data, we are the foremost public-facing sourceof cancer stats in the country. Working with the National Cancer Registration Service/ Public Health England, we are developing a patient portal to give those touched by cancer secure and supported online access to their personal cancer registry record, and our 'Local Cancer Stats' webpages provide a unique resource for looking at cancer data as that is easily comprehensible and suggests actions to address local issues.

We also have a highly motivated and intelligent workforce, and are increasingly employing people with an NHS background.

4. What is your policy regarding payment?

Many of our resources are free of charge and are available on our website. Where we are commissioned to provide a specific service, such as our primary care facilitators then a charge would be involved, usually this is to cover the costs to the charity.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?

With the new devolved system, there are many bodies involved in commissioning for cancer, which means it's very fragmented and can be confusing. Charities like Cancer Research UK can work with each commissioning body to provide clarity around commissioning responsibilities.

One of the benefits the third sector

Facts and figures

Number of dedicated staff in the healthcare team: 23
Current CCG, CSU and other NHS customers: CCGs: Camden, Enfield, Halton, Islington, Knowsley, Liverpool, Newham, Redbridge, Sefton, St Helens, Waltham Forest, Warrington, Western Cheshire Wirral; **CSUs:** North East London, Merseyside & Cheshire; SCNs (all)
Percentage of income from NHS contracts: Non applicable
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Non applicable
Service coverage/types of service provided: Cancer Commissioning Support (For CSS)
Main competitors: Undisclosed

has is that we don't have a performance management role and we're not part of the system, so we are seen as having very much a supportive role, helping to work with CCGs, CSUs, and LATs on an individual basis to help identify best practice and where we can anticipate improvement.

Charities also have an important patient advocacy role in ensuring that the patient voice is heard in service redesign.

6. What are the major challenges of working as a provider of CSSs?
When NHS funding is tight, there is a natural tendency for people working within the system to try to ensure resources are kept within the NHS. But it may be that it is more cost-effective to use external organisations who have the expertise needed.

7. What partnerships or planned partnerships do you have? Who does your network include?
We have a formal partnership with the RCGP and work very closely with strategic clinical networks. We're partners with NHS England and Public Health England for the Be Clear on Cancer campaign where we have provided project management support and evaluation and we have a leadership role in the National Awareness and Early Diagnosis initiative. On the research side, we are members of the National Cancer Research Initiative and the international Cancer and Primary Care Research Initiative. We are also one of the founding partners of the National Cancer Intelligence Network and continue to fund posts within the Network.

8. How do you see the CSS market evolving?
Unspecified

9. Do you have plans to enter into partnership arrangements with potential Lead Providers of CSS?
We are contracted by North East London CSU to provide Primary Care Facilitators in 7 CCGs and are in early negotiations with a further CSU to carry out some joint work around early diagnosis.

Biography

How does your career so far help you in working with the NHS?
My background is as an NHS manager and I've worked in a wide range of organisations including primary care, commissioning, acute trusts, strategic health authorities and the department of health. I also have personal experience of cancer, and this in combination with my NHS experience has been very helpful in my role here at Cancer Research UK.

What attracted you to working in this area?
The reason I'm working for Cancer Research UK is very simple, it's because having had cancer and being successfully treated, I wanted to give something back. Cancer Research UK is a fantastic organisation and being able to work here and at the same time be able to support the NHS, which I believe is the greatest healthcare system in the world, is an opportunity I couldn't turn down.

What do you enjoy doing outside of work?
I m a supporter of Manchester United, and I have lots of hobbies ranging from reading to sport, travel to eating.

Community Investors

Commissioning support services

Chief executive: Timothy Modu

1. How have you supported commissioners in the past, and what is your potential CSS offering?
Community Investors is a strategic development agency best described as a social enterprise. We offer high quality professional support and advisory services at an affordable price. In all our engagements, we aim to achieve:

- Structured problem-solving with fact-based analysis.
- Close collaboration with our clients.
- Result-oriented project management.
- Management of complex situations and multiple stakeholders.

Facts and figures

Number of dedicated staff in the healthcare team: Three - with the ability to call on professional associates or partner with others as necessary
Current CCG, CSU and other NHS customers: The Department of Health, clinical commissioning groups, local authorities and the NHS Confederation
Percentage of income from NHS contracts: > 60%
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Not yet applicable
Service coverage/types of service provided:

- **Research and development consulting**
- **Professional support services (technical and management)**
- **Public sector and service delivery**
- **Advisory and bespoke special projects service, including training on good practice in patient and public engagement/involvement in decision-making, joint strategic needs assessments, health and wellbeing boards, NHS Constitution, QIPP**

Main competitors: Undisclosed

- Access to quality expertise and solutions through our network.

We are experienced in providing policy analysis and reviews from a patient perspective at a national and local level. We have extensive experience in providing professional and technical support to enable patient involvement in commissioning decisions, including at a strategic level.

We are also used to working across health and local authorities and are skilled and knowledgeable in providing support and training on:

- Patient and public engagement and experience.
- Governance and accountability.
- Equality and diversity.
- Personalisation and long-term conditions.
- Healthwatch.
- Joint strategic needs assessments.
- Health and wellbeing boards.
- Overview and scrutiny.
- Involvement law.
- Quality, innovation, productivity and prevention (QIPP).
- How to find and use information.
- Public patient engagement.
- Reviews of policies and strategies.
- Using the NHS Constitution to ensure 'Right Care'.
- Third sector and social enterprise structures.

2. How is your business structured? How does CSSs fit into this?
As a small, strategic social enterprise company, our decision-making structure is designed to enable rapid but informed response and is led by the chief executive, with most of the operational decisions being shared between the core team of senior staff.

Project reference or steering groups where needed are established to suit the needs of each project and can include professional associates or expert patient and public representatives.

We can offer commissioning support services (CSSs) on a project partnership or alternatively on a directly-commissioned service basis.

3. What is different about your organisation, and why should commissioning organisations come to you?
We are an independent, flexible and highly-skilled team. We are very experienced in the field of health and social care development, especially from a patient and public engagement perspective, including at national level. We can often respond more swiftly and in a more focused way than larger organisations. We have in-depth insight and experience and can offer a unique perspective and understanding of patient and public engagement and how to use it as a commissioning tool. For example, how to use our findings and recommendations from our study on the Department of Health's State of Readiness for the NHS Constitution. This could be used to create a range of tools to 'constitution-proof' commissioning plans or reviews which could be rolled out nationally.

4. What is your policy regarding payment for providing commissioning support?
It is fee-based for services directly-commissioned by clinical community groups (CCGs) or CSS providers, or if by managed contract to CSS providers, by agreed schedule of service and payment in accordance with tender specification.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?
NHS commissioners face a scenario of exponentially expanding need, shifting resources, and infrastructure which is still bedding in as well as a workforce that is still in development and in need of 'firm-specific skills'. There is also likely to be an increasing measure of political risk in the run-up to the next election plus pressure generated by preparations for the necessary switchover from commissioning support units (CSU) arrangements hosted by NHS England to autonomous organisations using the lead provider framework to meet European Union requirements. CSSs, particularly those from strategic development organisations such as ours can add value by playing an enabling role

and ensuring that the insight and business intelligence gained from patient and public engagement is not lost. Social enterprises may also be more used to working across both health and local authority from a patient and public engagement perspective than other types of CSS providers. This adds value to outcomes, especially in terms of good practice in decision-making and on-the-job human resource development. VSOs like us are independent and can provide continuity at a local and national level by sharing knowledge and understanding of patient needs and insights.

6. What partnerships or planned partnerships do you have?
We have a range of professional associates we can call on as needed and are in the process of approaching potential partners among CSUs but also aiming to make CCGs more aware of what we have to offer. Professional associates qualified in the fields of health and social care.

7. What are the major challenges of working as a provider of CSSs?
Firstly, getting people to understand that they need our specialist expertise and secondly, to find us. We are independent and flexible so can partner where needed or be directly commissioned by CSUs, lead providers or CCGs.

8. How do you see the CSS market evolving?
As the job is more understood and as the overall infrastructure gets bedded in, although there will be large CSS providers providing benefits of scale, there is also likely to be more niche commissioning to respond to patient and public needs or to test markets for services.

9. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?
As small, strategic, niche provider, partnership arrangements are a key feature of our strategy for this work, including with potential lead providers.

Biography

How does your career so far help you in working with the NHS?
I have led my team of social entrepreneurs for over 15 years, first as Chief Executive of the local council for voluntary service CVS and then as CEO of Community Investors. We have always had a strong health and social care team and this has been and remains one of our key service areas. We have long been used to working in partnership with health and social care bodies and local authorities as well as with the local community, patients, carers and service users. I have found my earlier background in regeneration in Stratford as a member of the Stratford development partnership board for seven years very useful and informative when it came to developing our health and social care service, even more so now at this stage of transformation and integration of health and social care services nationally. For the last ten years, we have established and professionally supported the various statute-backed patient and public involvement forums, firstly under contract to the commission for patient and public Involvement and then various London local authorities.

What attracted you to working in this area?
My experience in regeneration and the motivation that comes from meeting up with the other members of my team and realising the incredible amount of combined skills, knowledge and experience we possess and discovering our ability to offer solutions to enable people in public services to get the job done while at the same time taking account of patient or public input (needs, ideas, views). This is the meaning of Community Investors.

What do you enjoy doing outside of work?
A variety of activities with family and friends, including watching football and studying economic and political history.

Diabetes UK

Commissioning support services

Head of involvement and improvement: David Jones

1. How have you supported commissioners in the past, and what is your potential CSS offering?
We currently offer support to commissioners through two main functions. Our regional managers work with decision-makers in local clinical commissioning groups (CCGs) to influence decisions about service design and improvement. They share our campaigns and knowledge to influence that process and improve the quality of diabetes care. They get involved in supporting service improvement and engaging local populations with diabetes. We also offer paid for support related to user engagement and risk awareness in black, Asian and minority ethnic (BAME) communities.

We are developing a wider portfolio of services and products to support quality improvement in local diabetes care.

We have good data about the quality of diabetes care across England from the National Diabetes Audit (NDA). Diabetes UK is a partner in the delivery of the audit. We take that data and a wide range of other sources to highlight areas for improvement. We are also working on better ways of sharing information about what works and different structural responses to the challenges of providing good quality, integrated diabetes care based on the real experience of areas who have had success.

We've just launched a new Clinical Champions scheme that will see us working with around 10 local clinical leaders to help them drive quality improvement in care. We will support this with a project looking at how we effectively support the development of local networks.

2. How is your business structured? How does CSSs fit into this?
We're a charity, overseen by a board of trustees who have high-level relevant skills and a relationship with diabetes of some sort. There are also two governance groups, the Council of Healthcare Professionals and the Council of People with Diabetes, who help guide our work to be relevant to our beneficiaries.

Our support for commissioners is delivered by our operations directorate, which includes our regional and national teams, and our policy and care improvement directorate, which includes our policy and product development functions and our equality and diversity team.

3. What is different about your organisation, and why should commissioning organisations come to you?
Diabetes UK is the leading UK charity that cares for, connects with and campaigns on behalf of all people affected by and at risk of diabetes:

- We help people manage their diabetes effectively by providing information, advice and support
- We campaign with people with diabetes and with health care professionals to improve the quality of care across the UK's health services.
- We fund pioneering research into care, cure and prevention for all types of diabetes
- We campaign to stem the rising tide of diabetes

We have extensive networks of people living with diabetes and are widely regarded as the voice of people living with diabetes. This allows us to support commissioners with a level of 'interested independence' that can help overcome barriers to quality improvement.

4. What is your policy regarding payment?
We share information and resources without charge. Our staff work with local systems to influence improvements in care. When we feel it is appropriate we can help with delivery of improvement initiatives. We do charge for our involvement when we are offering sustained support for improvement activity, delivery of some user engagement activity, our Community Champions programme and other forms of risk assessment.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?
There's a very serious issue around making change happen in the NHS in general. In diabetes, there are challenges to levels of engagement with patients and understanding patient experience, what good integrated care looks like as well as problems with the diffusion of good practice and innovation.

Voluntary organisations can be positive local partners who provide an independent voice from perceived governmental agendas or CCG funding constraints, with our role being to facilitate discussions and turn it back to the interests of diabetes patients.

6. What partnerships or planned partnerships do you have? Who does your network include?
We have partnerships with a large number of health care professionals working across diabetes care and the organisations that support them.

We also have partnerships with the National Diabetes Information Service, the information centre for our work in the diabetes audit, as well as partnerships across all different levels of the NHS. We have 2000 patients on the diabetes voices network, hundreds of community champions, and around 400 local voluntary groups. We also partner with religious faith organisations to improve our reach and we were Tesco's charity partner of the year.

Facts and figures

Number of dedicated staff in the healthcare team: 25
Current CCG, CSU and other NHS customers: Approximately 50 CCGs across the England, local and national systems in Scotland, Wales and Northern Ireland, CSUs, SCNs, HWBs
Percentage of income from NHS contracts: <1%
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Non applicable
Service coverage/types of service provided: Policy influencing, patient engagement, risk screening, quality improvement
Main competitors: Undisclosed

7. What are the major challenges of working as a provider of CSSs?
There are many strategic tensions, one of which is balancing the line between being a critical friend to commissioners and supporting them versus the role of our campaigning in holding them to account and challenging them to drive up quality.

Although there is a strong desire for organisations like ours to be active in the commissioning support market, there has been very little support to develop our infrastructure to do that. Ideally, we would like someone to give us a grant of a couple of hundred thousand pounds to allow us to develop our capacity to meet the needs of the market. Funds like the Investment and Contract Readiness Fund (ICRF) aren't feasible as it involves going to scale at a pace that an organisation like us can't currently take on.

The financial risk is even more evident given that it's difficult to establish what the market really is and whether it actually even exists. Whether or not VSOs will respond depends on the risk appetite of the boards. We're being asked to invest substantial amounts of money to invest in a risk-ridden business that's not been done before in any meaningful way.

8. How do you see the CSS market evolving?
It feels as though VSOs have a role, but the risk and the infrastructure development issues will stop many organisations from ever getting near it. I think a lot of boards are going to decide not to proceed on grounds it's too financially risky. It's hard to say at this point whether there is even a real market and whether anyone will be paying for CSS.

9. Do you have plans to enter into partnership arrangements with potential Lead Providers of CSS?
Yes, we are very open to that. A lot of strategic clinical networks and CSUs have already reached out to Diabetes UK, and our regional colleagues are making contact with them. Part of our strategy will be to identify who we can work alongside, as we know we won't be in a position to be a lead.

Biography

How does your career so far help you in working with the NHS?
I've worked in the voluntary sector for the last 18 years with a stint in the public sector, and all my roles have been about supporting people to get better care. I've worked in mental health, childhood deafness, and in Diabetes UK for the last seven years. My wife is a service manager in the NHS, so we talk about the NHS every night at home, you could say that I'm a little bit obsessed.

What attracted you to working in this area?
My dad and many relatives have diabetes. I think diabetes is a massive challenge, and getting diabetes care right is very complicated but necessary.

What do you enjoy doing outside of work?
I ride my bike for peace and quiet, and spend time being active with my 2 boys for fun.

Experience Led Care

Commissioning support services

National director: Georgina Craig

1. How have you supported commissioners in the past, and what is your potential CSS offering?

We work with commissioners to help them unpack the outcomes they want to achieve and support them by providing either an evidence-based, bespoke or ready-made programme and a 'turn key' programme that builds on existing best practice. We will be:

- Embedding outcomes-based commissioning.
- Developing person-centred service specifications with commissioners.
- Undertaking analysis of data from the Experience Led Commissioning (ELC™) programme to produce commissioning insights. Enabling commissioners to articulate meaningful experiential outcomes which could be included in contracts and attached to Better Care Fund bids.
- Building commissioner capability to be person-centred, outcomes-led by teaching people and organisations how to work in an experience led way.
- Coaching and accrediting commissioning managers, public health improvement leads, social care commissioners, managers within providers – including the voluntary sector - as ELC Practitioners.
- Investing in research and development of new ELC programmes in a variety of specialised commissioning including cancer; primary care transformation; seven-day working and outcomes-led commissioning of the Better Care Fund.
- Running our first ELC programme – a mirror provider side approach to improvement that enables providers and commissioners to work together seamlessly and generate shared insights to inform both commissioning and redesign simultaneously.
- Piloting a replicable model for developing user-led commissioning organisations with Disability Rights UK in several partner clinical commissioning groups (CCGs) for people with personal budgets.
- Creating innovative community-led outcomes measurement and performance management systems with people who use services across five commissioning communities who are eager to take this approach forward.

Facts and figures

Number of dedicated staff in the healthcare team: Five
Current CCG, CSU and other NHS customers: North Lincolnshire CCG, Wirral CCG, Sandwell and West Birmingham CCG, Durham Dales, Easington and Sedgefield CCG, North Durham CCG, Slough CCG, Herefordshire CCG,East Staffordshire CCG, South East Staffs and Seisdon Peninsula CCG, Staffordshire and Lancashire CSU, North Yorkshire and Humber CSU, Southern Foundation Trust
Percentage of income/work from NHS contracts: 80%
Approximate growth in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: 50%
Service coverage/types of service provided: service transformation, change management, community and clinical engagement and communication, co-design and redesign, analysis and insights generation, provider development and market management and other aspects of contract design and procurement
Main competitors: Undisclosed

2. How is your business structured? How does CSSs fit into this?

We're primarily a commissioning support organisation. ELC is our most widely spread programme. It has been developed to support outcomes-based commissioning and service redesign around: whole system transformation. Integrated care, long-term conditions management, urgent care (including specific programmes to understand the needs of frail older people; people living with long term health issues and young families), intermediate care, end of life care, weight management (including services for management of obesity), commissioning for improved outcomes with family carers, dementia care in the community, care home commissioning maternity services, outpatient redesign, diabetes, respiratory disease, vascular disease prevention.

3. What is different about your organisation, and why should commissioning organisations come to you?

As a social business that puts progress before profit, we build commissioner capability and capacity through organisational and individual ELC practitioner training and coaching. We know we've succeeded when commissioning organisations feel they no longer need our help. Our programmes are evidence based and built on insights from the University of Oxford's Health Experience Research Group, and our co-design and improvement methodologies are also evidence based.

We partner to undertake research into innovative person-centred commissioning practices. We anticipate change and developments in commissioning and constantly align and improve our programmes so that commissioners can respond rather than react to NHS England. We are also growing the evidence base for ELC. An independent evaluation has been published with further work comparing ELC with a control health economy to assess difference in cost and outcomes underway.

We align people with shared values enabling providers, commissioners, communities and frontline teams to work together to generate sustainable solutions.

Over the last two years, we have together won or been the shortlisted for eight national awards, including sole clinical commissioning group (CCG) nomination for the *Health Service Journal* 'compassionate care' award.

4. What is your policy on charging? Are there any plans for this to change?

We will invest our own time and resources in programmes that help fulfill our social purpose and are prototypes. We usually find a way to support commissioners that suits their budgets. We will partner with commissioning support organisations and can be funded through them. We often help commissioners identify funding to pay for our services from their budgets.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?

Many commissioners put effort and resources in running engagement events and programmes – but very little effort into analysing the data they collect. Too often they are not clear what exactly they want to find out and why which means the collected data does not translate into useful commissioning insight.

We add value by making sure CCGs ask the right questions which generate useful insights. We are yet to work with a commissioning organisation that understands how to analyse qualitative data and turn it into management insights, which we can help them to do.

Often the outcomes that matter are 'relational' and about how people feel, such as empowering people to self manage their condition. These more qualitative elements of care require new methodologies to be applied to measure change and improvement. Research shows that survey and measures of satisfaction are often blunt instruments and may not provide the rich insight providers and commissioners need to be responsive. This is why we are now working to invent new ways of holding providers and commissioners to account for outcomes. The premise behind outcomes-based commissioning is if commissioners set the right outcomes, providers will innovate and deliver them. In our experience, commissioners need help articulating person centred outcomes.

6. What partnerships or planned partnerships do you have?

We are currently working or have recently worked in partnership with: University of Oxford Health Experience Research Group, Kings College, Florence Nightingale School of Nursing, Staffordshire and Lancashire commissioning support unit (CSU), My Home Life, Boehringer Ingelheim, Royal College of General Practitioners, NHS Alliance, Pathfinder Healthcare Development cic, Soar Beyond, NHS Improving Quality, NHS England Domain 4 – patient experience team, NHS South Central Strategic Clinical Network (maternity and children), Capitated Outcome-Based Incentivised Commissioning (COBIC), L H Alliances, Rethink, Disability Rights UK.

We are planning future partnerships and joint working with: Voluntary sector organisations, pharmaceutical companies, CSUs and lead commissioning support providers, Year of Care Programme, Office of London CCGs, Strategic Clinical Networks, housing organisations, NHS England cancer team, NHS England primary care strategy team, NHS England long term conditions team and the NAPC.

7. What are the major challenges of working as a provider of CSSs?

These include: combining business development and delivery as a small medium enterprise, responding to complex tendering processes (we do not have the resources to do this and often find out about tenders too late), raising awareness of what we do with commissioners at scale, finding safe ways to enable commissioners to 'test out' this innovative new way of commissioning at low cost, protecting our intellectual property when working with partners.

8. How do you see the CSSs market evolving?

This is quite hard to judge as it currently feels highly dependent on the action that NHS England takes and how closely it seeks to lead market development. We would like to see the market develop so that CCGs continue to have a meaningful choice about where they source their commissioning support and so that the CS market is open to small niche providers and those who seek to innovate and offer new approaches to commissioning support. The move towards lead providers could potentially be high risk and limiting for SMEs and niche providers as it could result in a 'subcontracting only' as well as higher prices for CCGs

9. Do you have plans to enter into partnership arrangements with potential Lead Providers of CSS?

Yes we do.

Biography

How does your career so far help you in working with the NHS?
As a group we have worked for more than 25 years supporting the spread of innovation in NHS service delivery, influencing commissioning and policy around service redesign and primary care development. The team I work with contains experts in training, coaching people to drive person-centred change and change management. We have worked with academics over the last 15 years and understand the need to be deeply evidence based in the work we do.

What attracted you to working in this area?
We are a social business, passionate about embedding and spreading person centred care. We believe this is best achieved by working with commissioners to create a fertile environment for providers to do the right thing; deliver the outcomes that matter to people and innovate as they are doing this. This is why we have focused in the first instance on commissioning support.

What do you enjoy doing outside of work?
I like doing yoga and I also like looking after my two cats and chocolate Labrador, as well as being a good mum, friend and daughter.

Macmillan Cancer Support

Commissioning support services

Commissioning support programme lead: Beth Capper

1. How have you supported commissioners in the past, and what is your potential CSS offering?

Macmillan has been supporting excellent cancer commissioning for years, but not necessarily using the language of 'commissioning support'.

We can help commissioners understand the health and social care needs of their local population affected by cancer to inform service planning, strategy development, commissioning intentions and joint strategic needs assessments.

We can provide business intelligence and have quantitative data around incidence, prevalence, stratified pathways of care for some cancers etc. We use NHS data and commission original research, bringing patient insight and intelligence into analysis to make it useful in informing commissioning decisions.

Facts and figures

Number of dedicated staff in the healthcare team: 140+ staff in local and regional service development teams in England; centrally 100+ staff in services strategy and innovation; 65+ in policy & research

Current CCG, CSU and other NHS customers: Engaging with ~80% CCGs, a number of CSUs, a raft of providers, and working closely with many of the strategic clinical networks.

Percentage of income from NHS contracts: Non applicable

In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Non applicable

Service coverage/types of service provided: Strategy development; Business intelligence; Redesign; Communications; PPI; Evidence-based service solutions; Condition-specific expertise; Service reviews and evaluation

Main competitors: Undisclosed

With the National Cancer Intelligence Network, we'll be launching an interactive database - 'dynamic model' - in April 2014 to support cancer commissioning.

Our innovative Routes from Diagnosis programme maps the cancer journey for four tumour groups, at a population level, describing the stratified health outcomes of patients, for example, cancer and non cancer-related morbidities. It also looks at the patient's 'footprint' on the NHS such as hospital activity, cost and so on. We are piloting this with clinical commissioning groups (CCGs) in Sheffield and Manchester, supporting evidence-based service redesign.

We support involving patients and the public, working locally and nationally to ensure the voice of the patient is heard in the system. For example, locally, we're working with Doncaster CCG on a co-production approach to understand priorities for those living with and beyond cancer on issues around survivorship and support. Nationally, Macmillan's Value-Based Standard®, recommended by NHS England, is a quality framework for improving patient and staff experience and is being tested by Trusts and CCGs.

We're involved in both large and small-scale service redesign. In Staffordshire we're working collaboratively with five CCGs, two local authorities, public health and specialised commissioning on a transformational service redesign for end-of-life and cancer pathways, putting patients at the centre of care. It's one of NHS England's Integrated Care pioneer sites. In other areas, we may be supporting redesign on a discrete piece of the pathway.

We're also providing 'softer' support, bringing our well-established and locally trusted presence to help in networking and relationship building. Our long-term presence in an area and our view of the whole cancer care pathway, can be helpful at the moment when commissioning responsibilities have changed and the restructure has led to staff moving around and losing some cancer specialism.

2. How is your business structured? How does CSSs fit into this?

Macmillan has four directorates: Services & influencing, marketing and communications, fundraising and corporate resources.

Supporting excellent commissioning sits within our services and influencing directorate. This includes local teams of involvement coordinators, development managers and volunteering services managers. Nationally, it is made up of teams covering health and social care, inclusion, innovation, policy and research, professional engagement, service excellence and support, and support and wellbeing.

3. What is different about your organisation, and why should commissioning organisations come to you?

Macmillan shares the same goal as the NHS – improving patient outcomes and patient experience – and we work nationally, regionally and locally to support this aim.

We bring expertise in cancer, the voice of patients and an overview of the whole pathway – understanding what seamless care looks like for patients.

We have a great network of health and social care professionals (nurses, AHPs, social workers), with over 8,000 'badged' Macmillan professionals located in a range of partner organisations including Hospital Trusts, the community, other voluntary organisations, and Boots. We also have a network of Macmillan GPs, some of whom sit in CCGs.

The breadth of our work – from facilitating the involvement of patients to health data research to testing innovative service solutions to supporting service development – puts us in a great position to support commissioners.

We're quite different to others in that we don't bid for NHS funding for any services. Instead, we drive and 'pump prime' innovation in cancer services and support the spread of proven solutions, working with partners to look at how this can be sustained and replicated.

4. What is your policy regarding payment?

Macmillan has been supporting excellent cancer commissioning for years. Currently, we do not charge the NHS for our support. However, the formalisation of the 'commissioning support' market has introduced charging, and certainly when it comes to working with CSUs to support CCGs, we will be looking at what "autonomisation" of CSUs

leads to. Macmillan has a duty to its donors to spend charitable money wisely, and if, for example, we were supporting CCGs through working with CSUs who were independent and profit-making entities then we may consider payment.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?

The broad challenge is improving outcomes and quality of care on a reduced budget, while planning for rising demand due to changing demographics (the number of people living with cancer will double to four million by 2030). We've heard from commissioners that they don't have the headspace to think strategically and long-term. Everyone talks about shifting care from the acute to community setting, but unbundling spend is hard.

The voluntary sector can help support where changes have to be made, e.g. our partnership with the National Cancer Survivorship Initiative tailors care to the patient, empowers patients to take control and promotes self-management, increase efficiency in the system. We've been supporting developing of commissioning intentions and service specifications around this. Another example is our specialist care in the home service model, which is helping to reduce emergency attendance and admissions.

In the current system, there's a danger that for cancer, the care pathway could be fractured as the pathway is split between commissioning responsibilities. Our perspective is across the pathway. As commissioners consider outcomes-based commissioning, we can help identify measurable outcomes, and what patients value as a good experience.

6. What partnerships or planned partnerships do you have?

As well as established relationships with many Trusts, CCGs and strategic clinical networks we have numerous other partnerships; examples include a strategic partnership with the National Cancer Intelligence Network, a significant partnership with University College Hospital on the Macmillan Cancer Centre and research work with the Monitor Group on cancer health economics in Manchester.

7. What are the major challenges of working as a provider of CSSs?

The commissioning support 'world' is in a lot of flux at the moment, making it difficult for organisations like us who aren't seeking to be 'lead providers' to see where there are gaps and what's needed. We're not looking to duplicate or provide rival services, but want to focus on where we can add value because we understand cancer, bring the patient voice and have a wealth of experience and insight.

For the voluntary sector, I think our challenge is to clearly articulate what support we provide, and the impact it will have in improving outcomes and experience.

8. How do you see the CSS market evolving?

I think the lead provider framework will see the market consolidating, with CSUs partnering or merging to operate across bigger geographies and potentially specialising in different service lines. Additionally, more CCGs could bring their CSS in-house which would have a big impact. While the creation of this market is an opportunity for Macmillan to demonstrate how we can support commissioners, we have been doing this for a long time and will carry on whether the CSS 'market' exists or not.

9. Do you have plans to enter into partnership arrangements with potential lead providers of CSS?

We don't have any formal partnerships lined up, but we're always open to conversations. We're already speaking to some CSUs about service development and business intelligence. We'll be working with Cheshire & Merseyside and North of England CSUs this year piloting work on user involvement and shared decision-making.

Biography

How does your career so far help you in working with the NHS?
I have worked for the Department of Health Cancer Policy Team leading on the national patient experience survey and working on the national Awareness and Early Diagnosis Initiative, supporting Cancer Networks and primary care trusts with local implementation. My work in the third sector has focused on health, social care and welfare from both a policy and operational perspective. In my current role I have the pleasure of working with individuals and teams with a wealth of experience in health and social care, looking at how we can use this to support excellent cancer commissioning.

What attracted you to working in this area?
I'm a proud believer in our NHS and have seen so many friends and family served brilliantly by it. But we all know the incredible pressures the system is under at the moment; just taking the number of people living with cancer as an example – it's obvious we can't double the amount of services to support the four million expected by 2030. I believe commissioning is absolutely key to doing things differently. I'm driven by working with NHS colleagues to improve cancer patient outcomes and experience and have healthcare that is designed around the patient not the system.

What do you enjoy doing outside of work?
I enjoy running, navigating my way through busy London streets on my road bike and exploring new places.

Marie Curie Cancer Care

Commissioning support services

Head of commissioning, patient services: Paul Harniess

1. How have you supported commissioners in the past, and what is your potential CSS offering?
We've been offering service re-design expertise to commissioners and stakeholders for near enough 10 years through our Delivering Choice Programme (DCP) which has helped create or modify service models in 20 different locations. So, we have significant experience in this area and we've learned along the way from interactions with many commissioners and stakeholders around the country.

This work has ranged from a complete end-of-life care system review in a locality to more discrete, well-defined projects that support a commissioner's review process, so we offer flexible and scalable support. The methodology is robust and proven, typically starting with a review of services and the level of need, making use of our own and independent sources of data, together with workshops that we convene and facilitate among existing stakeholders. We would then make recommendations and the case for change, and potentially help implement them.

2. How is your business structured? How do CSSs fit into this?
In England, patient services is structured around five regions, which are responsible for developing and managing our services to patients through a community-based nursing service, five hospices and a volunteer service. Each region has a business and service development team which is responsible for working closely with clinical commissioning groups (CCGs) and commissioning support units (CSUs) to identify levels of need and appropriate service delivery models to ensure the best patient experience.

3. What's different about your organisation and why should commissioning organisations come to you?
Firstly, by virtue of our wide geographical coverage, we have the advantage of being able to share our experience of what has worked in other areas of the UK.

We're also very pragmatic, in the sense that as a provider of end-of-life care, we can offer a practical slant on delivering solutions and provide an understanding of what patients need. Where we do make recommendations, we're drawing upon experience of having done something similar elsewhere and can speak with confidence about what's actually deliverable. At the same time, we pride ourselves on being objective; as a charity, we'll always focus on what's best for the patient and won't be clouded by commercial gain. Our recommendations are also based on rigorous analysis and consensus between multiple stakeholders.

We attach great importance to evaluation and have a team dedicated to managing evaluations. Once we have evaluation results, rather than be protective of our knowledge, we aim to make our findings widely available be it through one-to-one discussion with commissioners, workshops, events, websites etc.

4. What is your policy regarding payment?
We typically leave that open to discussion as it depends on the nature of the service re-design project, for example, the objectives and the time and resources it might take to achieve these. A contribution to project costs might underpin a partnership of this kind.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?
I think the biggest challenge that commissioners face is that they bear the major burden of responsibility for changing the system, which is clearly unsustainable as it is—and the clock is ticking. Identifying where to devote their efforts, establishing a clear plan and priorities and quickly accessing the expertise they may need to bring in, be it through CSUs, voluntary sector organisations etc. is akin to trying to change the wheels of a moving car – and the car is picking up speed!

The best way we can help is to make sure that CCGs and CSUs clearly understand the expertise we can offer. For example, our brand, Marie Curie Cancer Care, suggests that we only provide care to cancer patients—but actually 25-30% of our patients suffer from illnesses other than cancer such as respiratory disease, heart failure or dementia, and we have knowledge of planning and providing end-of-life care for these groups.

We know that commissioners value this understanding because cancer care pathways are now fairly well defined in both acute and community settings but less so for non-cancer patients.

6. What partnerships or or planned partnerships do you have?
Across the breadth of our service development, nursing service, hospice, policy, fundraising, research and communications teams, our partnerships are extensive and too numerous to mention. In terms of service development, we'll sometimes find the start point is a meeting of minds between the commissioner and one or two other key stakeholders in the locality

Facts and figures

Number of dedicated staff in the healthcare team: 40 (Business and service development team only).
Current NHS customers: Our nursing and hospice services achieve a 95% coverage of the UK population (by commissioning areas).
Percentage of income from NHS contracts: 32%
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Both our NHS income and patient numbers have grown year on year although it's difficult to attribute this solely to the structural reforms
Service coverage/types of service provided: End-of-life care service re-design specialist; provider of end-of-life care nursing and hospice services in the community
Main competitors: Undisclosed

leading to discussions about who we might get involved in a partnership project. We have recently established a three-year strategic partnership with the Royal College of General Practitioners (RCGP), the focus of which is to raise levels of commissioning knowledge about end of life care among GPs and non-clinical commissioners.

7. What are the major challenges of working as a provider of CSSs?
Probably the opposite of the challenge commissioners face in trying to understand the range of support available to them. While we can articulate our offering, the challenge is to make sure that our voice is heard and understood in the midst of the myriad information that is also trying to attract commissioners' attention.

8. How do you see the CSS market evolving?
In a free market, the successful organisations will be those who can show that they understand the needs of commissioners and respond best; that's going to determine the winners and losers. Whether that's going to be existing CSUs, new organisations that come through as mainstream accredited framework providers or other organisations working in partnership with them or directly with CCGs remains to be seen. I'd like to think we'll witness everything from a CCG making a wholesale change to their commissioning support arrangements to the other end of the scale—and I suspect there will be quite a body of CCGs here – to those who will strengthen their commissioning support based broadly on the same relationships. I think it might be too much to expect for commissioners to focus on transforming the health and social care system and the same time as making wholesale changes to their commissioning support, although recognising these are interdependent.

9. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?
We already enjoy a close relationship with many CCGs and also have a general agreement in place with one CSU that recognises the added value that our knowledge and expertise can afford those involved in reviewing and re-modelling end-of-life care. We're very open to the prospect of working with others and ultimately keen to find the partnerships that work in the best interests of patients and commissioners. We are strong supporters of the compact between ACEVO (Association of Chief Executives of Voluntary Organisations) and the CSU Network and hope that this will lead to further partnerships with like-minded CSS suppliers.

Biography

How does your career so far help you in working with the NHS?
I have a broad commercial background that has taken in other industry sectors which enables me to bring a different perspective to healthcare. I've been involved in supplying services to the NHS for the last 10 years.

What attracted you to working in this area?
What I enjoy most about healthcare – being able to make the comparison with other sectors – is its complexity and the challenges that brings. I like the fact that healthcare is part of the fabric of our society. For me, the combination of a strong personal and professional interest is a powerful motivator.

What do you enjoy doing outside work?
Mainly trying to stay reasonably fit and healthy – by playing racketball, real tennis (played on an asymmetrical indoor court) and skiing.

Mind

Commissioning support services

Director of network and communities: Karen Mellanby

1. How have you supported commissioners in the past, and what is your potential CSS offering?

Our focus is on ensuring commissioners can obtain the right information about what services are most effective at improving the outcomes for people with mental health problems. We have supported commissioners to engage effectively with people who use services and local voluntary sector providers so that they channel scarce resources in the right direction. This has involved: local health needs assessments to address gaps in provision; feedback on the patient experience to design and deliver effective care pathways; and partnership work to develop and test new approaches to commissioning integrated mental health services that respond to local and complex needs.

We draw from our nationwide network of 154 local Mind service providers and our 2000 members with lived experience of mental health problems to deliver commissioning support. For example, Mind has been actively involved in the introduction of the Alliance Contracting model for collaborative commissioning in Stockport, which has seen the development of a common outcomes framework.

We work in partnership with other national voluntary sector organisations (VSOs), for example Mind is one of four charities that has come together to develop the MEAM (Making Every Adult Matter) approach to helping areas design and deliver co-ordinated services for people with complex needs. We also work closely with specialist partners, such as the Innovation Unit, who have been at the forefront of people powered health initiatives in Lambeth. This has led the development of a robust methodology for co- designing mental health services in partnership with commissioners and the people who will use the services.

Facts and figures

Number of dedicated staff in the healthcare team: A flexible resource pool of around 200 mental health experts

Current CCG, CSU and other NHS customers: National and local relationships covering all regions of England

Percentage of income from NHS contracts: The local Mind network is contracted to deliver approximately £20million in NHS contracts, representing around 31% of network income

In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Undisclosed

Service coverage/types of service provided: England wide mental health services; Mental health prevention, well being and crisis care; Integrated commissioning; service co-design; product development; needs assessment; patient and public involvement; mental health training.

Main competitors: National independent providers

2. How is your business structured? How does CSSs fit into this?

Mind is a national charity employing 200 staff to work across a range of functions including; policy and campaigns; research and information; programme delivery; local service strategy and development; and fundraising. We have a federated network of 154 local Minds that operate as independent charities and deliver a wide range of mental health services to a third of a million people annually. This network employs 2,500 full time staff and engages over 10,000 volunteers. We also have a retail arm of 140 Mind shops and over 2,000 people with lived experience of mental health problems that have joined Mind who are keen to influence the development of mental health services in their local areas.

We draw on these networks and work in partnership with other specialist partner agencies to build flexible teams to provide tailored commissioning support services.

3. What is different about your organisation, and why should commissioning organisations come to you?

Mind is the leading mental health charity in England and Wales. We campaign to ensure all people with mental health problems have access to support and respect. Our network of local Minds is one of the largest providers of mental health services in the country. We know that people who use mental health services have a valuable contribution to make to the design and delivery of future services and can harness this expertise through our networks.

As mental health moves up the policy agenda, the government has set the clear priorities for change, leading to mental health having equal priority with physical health and for everyone who needs mental health care having access to the right support at the right time.

This poses significant challenges for commissioners. Mind is in a strong position to share our knowledge and utilise our local networks and expertise to support new commissioning approaches that can provide choice for service users, and lead to the design and delivery of integrated personalised services that can promote recovery.

4. What is your policy regarding payment?

Mind shares good practice and is committed to working in partnership with commissioners locally to further our charitable aims and deliver specific programmes of work. For more tailored commissioning support that draws on a wide range of expertise from across our networks and partners there would be costs associated with our support.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?

There's a lot of pressure on them to deliver more for less at a time when we are seeing a higher profile around mental health than ever before. The need to commission high quality recovery-focused mental health services that respond to local need is a priority, and they need to have the knowledge and expertise to

come up with models to commission effective services that meet that need. Currently, there is often limited choice in terms of mental health support and the default option is often to prescribe medication when interventions, such as access to talking therapies and peer support provide more effective alternatives. Financial pressures means it is more important than ever to focus on commissioning services that work and that prevent reliance on more expensive crisis based services.

However, very often GPs responsible for the referral pathway aren't aware of the body of evidence supporting alternative therapies and might not have had the training about what's available, which is where voluntary sector organisations such as Mind, who have access to evidence-based practice, could provide support.

CSSs are key to helping to develop and promote models of commissioning that lead to quality provision that delivers outcomes to meet local need. Engaging local voluntary sector providers and service users in this task will be crucial.

While commissioners often commission for economies of scale, it's also important to commission for economies of scope that cater for local needs are more person-centred, and more integrated, which voluntary sector service providers can achieve through their local knowledge and having trusted relationships within the community.

6. What partnerships or planned partnerships do you have?

We have 154 local Minds who are our community partners. We also work in partnership with a range of national charities, including Rethink Mental Illness on the Time to Change campaign; and Homeless Link on the MEAM approach.

The Innovation Unit is our innovation partner and we work with them on service redesign. We regularly work with other partners and consultants to develop and deliver programmes. We work particularly closely with consultants who have lived experience of mental health problems and organisations that can assist us to bring the mental health service user voice to the forefront of our work.

Biography

How does your career so far help you in working with the NHS?

I'm a qualified social worker and worked for many years providing independent advocacy services, supporting people who used local authority and health services to say want they want, make choices, know their rights, and access the services and support they need. I then moved on to support the infrastructure of independent advocacy services nationally and worked to support the implementation of advocacy services in relation to the mental health act and the mental capacity act. Prior to Mind, I worked for a number of years as director of programmes at Locality, leading the delivery of major government programmes in relation to the Localism Act, including community asset ownership and community service delivery.

What attracted you to working in this area?

For a long time, I've believed in ensuring people have access to a choice of good services that meet their needs. And I'm passionately of the view that local people and communities can be involved in delivering and coming up with solutions in partnership with services. It's great that Mind has that national presence to campaign for important issues and to break down that stigma around mental health while being able to support local people to design and inform their own services in partnership with others.

What do you enjoy doing outside of work?

I travel regularly to the US to visit family and enjoy going to the theatre. I'm also an assistant scout leader so I enjoy supporting young people in the local area to take part in in a range of activities including regular camps and outdoor activities.

7. What are the major challenges of working as a provider of CSSs?

The market is still developing and there is a lot of competition and uncertainty, especially for voluntary sector providers, who are still clarifying their specific role and offer in relation to independent providers. It will be important early on that we can work collaboratively with CSUs and the independent providers to ensure our unique offer and expertise is valued and incorporated. Persuading commissioners to move beyond the short-term attractiveness of economies of scale to really recognise the value of local solutions and co-design approaches will also require a significant culture change. We will need to be able to evidence impact effectively.

8. How do you see the CSS market evolving?

Commissioners will be needing a range of commissioning support which CSUs, independent sector providers and VSOs will have their respective strengths in delivering. So, moving forward, I can see more effective collaborations between CSUs, individuals and VSOs, and it'll be important to support that and enable that to happen.

9. Do you have plans to enter into partnership arrangements with potential lead providers of CSS?

Yes we are exploring that currently. We have seen a significant increase in approaches recently and feel that we have a strong specialist offer to more general lead providers.

Multiple Sclerosis Society

Commissioning support services

Head of service change and development: Sally Hughes

1. How have you supported commissioners in the past, and what is your potential CSS offering?

Our current service development function at both a national and local level is based on an influencing model rather than a formal / paid commissioning support service (CSS), therefore it is currently free at the point of engagement. We focus on raising standards of care for people affected by multiple sclerosis(MS) by working in partnership with professionals, people with MS, volunteers and decision makers, using of service improvement tools to develop new approaches and services.

While improving outcomes for people with MS by working in partnership to address required improvements in commissioning and practice of MS services is in line with our current strategic objectives, we expect to complete a strategic review of our market position in relation to the development of support and services for people with MS over the next 12 months, this may include the expansion of commissioning support services.

Our current commissioning support offer can be limited to a single issue, such as contributing evidence to a review of specialist nurses, or involve a whole system review of compliance with national guidance and recommendations regarding pathway redesign from diagnosis through to end of life care for people with MS.

2. How is your business structured? How does CSSs fit into this?

The MS Society established a commissioning support service called Neurological Commissioning Support (NCS) in 2007, which became a limited company in 2010/11, in partnership with Motor Neurone Disease Association (MDNA) and Parkinson's UK (PUK). NCS operates as our commissioning support arm for contracted commissioning support services as part of our wider service development and influencing programme.

MS Society staff and volunteers support MS condition specific developments aimed to improve standards across health and social care in line with the model described in question 1. However, they work alongside NCS to provide local context to any work undertaken and to ensure any recommendations from NCS work have a clear a exit strategy and sustainable activity such as participating in local neurology networks /alliances that are set up.

3. What is different about your organisation, and why should commissioning organisations come to you?

The MS Society has provided significant research investment into the development of evidence-based interventions and service models to improve outcomes for people with MS. In addition to this, we have access to service improvement tools that can support problem analysis at a system level (such as analysis of hospital episodes statistics (HES) and patient survey data) or individual service area such as Cost Calculator© to illustrate the cost-effectiveness of multi-disciplinary teams and single spoke roles. Working on this basis not only can we identify areas for improvements but we can also make recommendations regarding evidence-based interventions that address challenges of doing more with less.

4. What is your policy regarding payment for providing commissioning support?

Our in-house support provided by staff and volunteers is provided on a free basis at present. We recognise that MS is a relatively rare condition and therefore it is sometimes more important to raise awareness of the benefits of providing excellence in care and support and highlighting costs associated with inappropriate or unplanned care.

If the required commissioning support has been put out to tender, and is a service that would have previously been undertaken by the commissioners of that service, we would regard that service to be fully remunerated and appropriate to be delivered on a contractual basis via NCS as our commissioning support provider.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?

NHS commissioners face a number of challenges namely succession planning, capacity and capability. The changes in the commissioning landscape since April 2013 mean that there has been a void created in terms of the organisational memory of why services were established, the historical investment made and progress made to date. VSO organisations such as the MS Society are well placed to support commissioners to build their knowledge in this regard to support succession planning.

MS is a variable and fluctuating condition and there is a capacity challenge for commissioners to discharge their duties to meet the needs of people across the condition in terms of planning for episodes of acute care. This includes diagnosis services and disease modifying therapies through to programmes that address long-term care and management ,such as access to district nursing and self-management programmes. Commissioners will

Facts and figures

Number of dedicated staff in the healthcare team: We have 21 staff across the UK dedicated to service development of which 16 are in England (linked to regional SHA areas)
Current CCG, CSU and other NHS customers: Not on a paid basis however we are working extensively with strategic clinical networks, CCGs, NHS England, Health and Wellbeing Boards and Health Watch
Percentage of income from NHS contracts: 0%
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Non applicable
Service coverage/types of service provided: Service audits using quality neurology, measuring success audit tools, patient engagement and surveys, professional engagement and business planning support (For CSS)
Main competitors: Undisclosed

often want to procure services that meet the majority of care needs for that patient group however MS does not follow a typical trajectory and needs core elements provided across the continuum. Tools such as the Neuro Navigator can help commissioners to plan for this and build commissioning capacity and capability.

6. What partnerships or planned partnerships do you have?
The establishment of NCS shows the foresight that VSO can have in anticipating the needs of the commissioning system to support objectives to improve outcomes for people with MS and other neurological conditions.

We continue to work in partnership with the partners that established NCS but also the wider neurological community and VSO.

7. What are the major challenges of working as a provider of CSSs?
One key challenge is the recognition and validation of the VSO in having the skills and competence to provide services of this nature. The sector has a responsibility to demonstrate its capability however the CSS and wider procurement and tendering processes need to adhere to best practice regarding procuring from VSOs to ensure there is a level playing field on which they can enter the market place. Commissioners often regard the role of VSO as 'service providers' in delivering services and not necessarily as partners who have core knowledge to develop services strategy.

A further challenge is to recognise that strategic commissioning is entirely different to a procurement role. There continues to be confusion about the relationship between strategic commissioning and procurement.

MS cuts across commissioning responsibilities of NHS England specialised commissioning and the role of CCGs. A failure to clarify this means many CCGs do not see that they have core responsibilities for commissioning neurology and more specifically MS services such as multi disciplinary teams.

8. How do you see the CSS market evolving?
One potential evolution is to explore how the CSS could subcontract elements of condition specific /locality interest to the VSOs.

Biography

How does your career so far help you in working with the NHS?
I have worked in extensive commissioning and service improvement roles in the NHS and social care therefore have the relevant professional background to extend to developing partnerships at a national and local level with CSSs.

What attracted you to working in this area?
I left the NHS ahead of the major reorganisation expected at the point at which the coalition government came into power (2010) and wanted to bring my skills and experience of working in commissioning and strategic planning to the voluntary sector. I have personal experience of MS and wanted to apply by skills to be benefit of the 100,000 people living with MS rather than just to the people I know living with MS.

What do you enjoy doing outside of work?
Not working! I am a season ticket holder of Nottingham Forest Football Club.

9. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?
NCS are currently exploring this. This is not something the MSS is actively exploring at this point.

Neurological Commissioning Society

Commissioning support services

Chief executive: Sue Thomas

1. How have you supported commissioners in the past, and what is your potential CSS offering?

Currently, we provide support around auditing, business intelligence, pathway redesign, project management for service transformation, clinical leadership and engagement, as well as patient and public engagement through consultations. We take a very evidence-based approach to commissioning support, and one of the things we do on the majority of our work is to provide a deep-dive data analysis of neurology performance. Through Hospital Episode Statistics (HES), we'd look at the top 10 spend performance of neurological conditions and provide commissioners with an evaluation of performance including an analysis of the main problems and potentially how they can be rectified.

We also tend to evaluate how services are running from both a patient and professional perspective, looking at some key outcome measures we have on a validated audit tool we developed with funding from the department of health. We might then give commissioners advice on or help to project manage service model redesign through the co-production of services – so using the views of patients and professionals to implement shared decision making around service transformation.

2. How is your business structured? How does CSSs fit into this?

The whole business is a commissioning support business. We were set up in 2008 by our partner charities Parkinson's UK, the MS Society and Motor Neurone Disease Association to improve services for people with neurological conditions before commissioning support was even talked about. Being voluntary sector, we have a board of directors who are the CEOs of our partner charities. We also have a senior management team who are locality-based commissioning advisors. Then there's a sub-structure of admin and marketing and communication staff. When we get a project, we have a project manager who leads from NCS, then, we would also have a local manager working to deliver the work. The core team is 16 people, but we work alongside the charities as well, so our charity staff may well work with us on a secondment to deliver aspects of the work we're doing.

3. What is different about your organisation, and why should commissioning organisations come to you?

Primarily, because we are the experts in terms of providing commissioning support for neurology. Our knowledge base is not only from the expertise of our core team, but also the patients that we work with. Our charities give us a huge wealth of understanding about what it is like to live with the condition and expertise about how patients should be managed. It would be very difficult for any of the commissioning support units (CSUs) to have this type of expertise because it's grounded in reality. Working day-to-day with neurological conditions, we understand them inside out – so I guess we're kind of a best of breed really if you want to use NHS England terms for the work we do. It's highly niche, but our central focus is always the patient, and we bring that service user perspective in every single thing that we do.

Our team is also made up of lead commissioning advisors who have strong clinical backgrounds, with a neurology focus being a constant theme throughout. This includes members who have worked in the King's Fund, the audit commission, as well as worked previously as commissioners, providing us with different expertise as required.

An example of a commissioned piece of work is our work with both NHS Kernow and NHS Vale of York clinical commissioning groups (CCGs). We did a whole review of their neurology services and provided suggestions to meet patient needs in a different way, such as a 'one-stop shop' on their high activity areas like Parkinson's, which both CCGs have set up quality innovation productivity and prevention (QIPP) programmes around this year.

4. What is your policy regarding payment?

We have a pricing structure currently for our work. However, our main raison d'être for work has been to improve services for people with a long-term neurological conditions, so in some cases, the partner charities may support work where services are considered to be poor, but on the whole, we would hope to be paid for the expertise we share. The kind of work we do is very detailed and has the potential to create greater efficiency and better patient outcomes – so hopefully of great value.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?

A challenge for CCGs is commissioning the appropriate services for their patients. Patient and public involvement is not always being fed into commissioning decisions, which are instead traditionally based on historical

Facts and figures

Number of dedicated staff in the healthcare team: 16
Current CCG, CSU and other NHS customers: Strategic clinical networks (East of England, East Midlands, Wessex, Thames Valley, West Midlands); CSUs (North and North East London); CCGs (Vale of York, Waltham Forest)
Percentage of income from NHS contracts: 40%
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: 6.5%
Service coverage/types of service provided: Health needs assessments, business intelligence, support for service redesign, communications and public and patient engagement; support with clinical engagement and leadership
Main competitors: Larger CSS providers such as PWC or United although we could also be partners in providing them with specific commissioning support related to neurological conditions

perspectives or what CCGs feel are required.

There may be a risk of commissioning services that patients don't actually want. For example, what has come out time and time again in our work is that patients want more information about how they can self-care and self-manage. They don't necessarily want to have to go back into hospital or to the different sorts of services that are in place. So, by providing an understanding of what patients truly want, bringing our breadth of understanding of what's in place nationally, and what is or isn't working in each region, we enable the cross fertilisation of ideas and help commissioners to get a wider perspective for the potential of service redesign.

6. What partnerships or planned partnerships do you have?

We have our three partner charities: Parkinson's UK, the MS Society and Motor Neurone Disease Association, and also our affiliate partner charity, Epilepsy Society. Depending on the work we're doing, we also make contact with other charities as appropriate.

For example, for the work we did with the South West Strategic Clinical Network to identify their top 10 activities in the south west to develop a profile for how services were being delivered for each disease area, we liaised with a range of charities including the myasthenia gravis, dystonia and Huntington's charities.

We also mentor a group of charities to support them in developing their own commissioning support functions including Macmillan Cancer Care, British Heart Foundation, a coalition of the spinal injuries and rheumatology charities. We've also got a partnership agreement with CSUs and are talking to others about potential partnership agreements.

7. What are the major challenges of working as a provider of CSSs?

Some of the major challenges from the voluntary sector has been recognition from CCGs and CSUs that we can actually do the work and that we are in the market for business.

Though we are working on multiple contracts at the moment we would like more. From a meeting I chaired to formulate the Nuffield Trust report on the role of the voluntary sector in commissioning support it was obvious that CCG and CSU knowledge of the voluntary sector is very limited. So from a voluntary sector perspective, we need to be clear about what we have to offer and get the message out.

The voluntary sector also needs some support nationally from people like NHS England, reinforcing our credibility. There are also contractual barriers and conflicts of interest for others in the voluntary sector who may additionally be a provider of services. The logistics of small business development and sustaining cash flow while expanding the business of commissioning support are also big challenges to the voluntary sector.

8. How do you see the CSS market evolving?

I'm hoping that more of the voluntary sector will come in and support CCGs /CSUs in delivering commissioning support. I would hope that more partnership agreements will be made between CSUs and other commissioning support providers so that people like us who've got expertise in particular areas will be able to support the partnership workings.

9. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?

It's something we would definitely consider. We are also open to being a lead provider potentially as a coalition of charities including those we are mentoring.

Biography

How does your career so far help you in working with the NHS?
I've worked in the NHS for the whole of my career. My background is in nursing, then I worked at the Royal College of Nursing as policy and practice advisor for 18 years. My clinical expertise is obviously enormously helpful in terms of the work that I do, and my understanding of policy and NHS management is really beneficial to us because we can understand the policy levers that would help us in terms of providing commissioning support to CCGs. I've also got a strong voluntary sector background as well, and obviously all these things added together are very helpful.

What attracted you to working in this area?
I've always wanted to work in health. I guess really it's to try and improve services for people. When I worked in clinical practice, I was able to make a difference for patients within my clinical team. The reason I moved into policy and then into this is because of the wider implications. I can now help whole populations rather than a defined caseload.

What do you enjoy doing outside of work?
Gardening is my number one thing, and then travelling. If it's winter, then skiing.

Stroke Society

Commissioning support services

Director of life after stroke services (North of England): Elaine Roberts

1. How have you supported commissioners in the past, and what is your potential CSS offering?

We have been providing integrated service on behalf of the NHS and or local authorities for more than 30 years. We also work with commissioning support units (CSUs) and clinical commissioning groups (CCGs) and others to identify gaps within stroke service provision. We may help with defining a set of Planning Performance and Quality measures for a stroke service or by assisting in outlining the needs of a stroke service within a tender. With CCGs having grown and developed only in the last two years, there may be cases where individual commissioners who have come from other areas of working may have had no engagement with stroke service provision. So it's important for them to gather information about what that might look like to include support enabling patients and their families to live with stroke as a long-term condition. We are always keen to provide evidence and examples of good practice, which informs decision-making.

As a national organisation, we host the UK stroke forum annual event on behalf of the professional stroke community enabling clinicians, therapists, researchers, nurses, and also GPs and commissioners to share good practice and information about new developments in stroke treatment or services. We are also charged with providing the Stroke Specific Education Framework, which endorses education and training programs for improved stroke treatment and care in the UK. We are the leading funders of stroke research and have a wealth of information, which we share widely within the stroke world and are keen to do so more widely at a local level with commissioners. Several publications are available by contact with the local regional offices or via our website.

We regularly share service user experience with commissioners and facilitate service user consultations to inform development of the care pathway, such as in the Wirral and in Salford. While commissioners may have access to data, if they are confronted with the data for the first time, they may not be able to elicit all the detail or relevance of it. For example, in one instance, our data revealed higher stroke incidences than was suggested from the quality outcomes framework data they had, proving to be more accurate. We also capture data long after patients have left hospital which can inform future planning or service review. We are commissioned in some areas to undertake formal six month reviews which are then reported into systems such as the SSNAP Stroke Specific Sentinal Audit which can provide useful patient management and personal experience information for commissioners.

Facts and figures

Number of dedicated staff in the healthcare team: 40
Current CCG, CSU and other NHS customers: We currently have 226 'active' contracts
Percentage of income from NHS contracts: £11,483,900 is the current active contract value for 2013-14 – this includes income from NHS contracts as well as those funded by alternative funders, e.g. local authorities
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Undisclosed
Main competitors: Undisclosed

2. How is your business structured? How does CSSs fit into this?

We are a UK-wide organisation divided into the devolved countries and regions. Each area may work differently due to the local statutory requirements and deliver slightly different things, however, they are working to the same overarching business strategy, quality standards and objectives as a national organisation should. As director of North of England, I have five regions each managed directly by a regional head, whose responsibility it is to provide leadership to their local workforce and to work in collaboration with statutory providers for the benefit of the stroke community.

3. What is different about your organisation, and why should commissioning organisations come to you?

We are the only UK wide stroke charity and at any one time we would be supporting thousands of people affected by stroke through delivering stroke services within the NHS and local authorities as well as providing our own local social support structures of our own groups and affiliated clubs. We are therefore able to be a strong advocate for the needs of stroke survivors and their families. We are experienced at balancing our service provider role and being that voice of the stroke community very professionally without either of our roles affecting the other. We are a very mature organisation with clear boundaries, able on the one hand to say what you're delivering isn't good enough and on the other, able to do business with that group of people commissioning services. For charities to retain their credibility, they have to remain the voice of their community alongside being the potential service provider, and all charities that deliver services have that challenge to face.

4. What is your policy regarding payment?

Currently we don't charge for that support unless commissioned to do a specific piece of work set out by the commissioners such as a consultation exercise. It is possibly time for us to revisit our position of routinely providing what is very useful understanding and knowledge of stroke services delivery, without receiving the financial recognition of the value of that. Particularly as the commissioning support structures and bodies have themselves changed and developed into private enterprises who may in turn charge for the support they provide to CCGs.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?

Obviously the pot of money is more limited than it has ever been, and so commissioning needs to be clear about what it is trying to achieve and what the true value for money

is beyond the sometimes narrow perception of what is commissioned and what therefore should be measured.

We can assist them to gain a broader user opinion and experience though links we have with people with condition specific experiences, which may not otherwise be easily acquired.

To commission more efficiently, commissioners need to ask questions relevant to the various services they are commissioning from VSOs. They need a better understanding possibly that VSOs are all different and that just as it is a challenge for CCGs and LAs to work collaboratively and effectively, it is equally a challenge for us, and not something which can be developed overnight. We would be pleased to assist and often do where enlightened CCGs ask us to help.

6. What partnerships or planned partnerships do you have?

We are currently work collaboratively with other charities to develop prevention activities where our missions visions are of a similar nature and where joint working will benefit our communities. For example, we have worked with British Heart Foundation and Diabetes UK, having risk factors in common. We also are members of the local cardiac and stroke networks, where they are still working effectively

7. What are the major challenges of working as a provider of CSSs?

For any organisation such as ours, a challenge is walking the tight rope between being a provider as well as potentially offering commissioning support, which determines what services should look like. We have in many ways however already done that in relation to the old commissioning landscape.

We have to be able to take that balanced and credible position of identifying a conflict of interest should it arise but ensuring we are advocating for our constituents whether or not there is a financial interest for us by remaining the voice for stroke.

What has changed is we could be advising a private enterprise or body, who in turn receive financial reward for then imparting that information we provide as theirs. Charities therefore need to be aware of their value and the knowledge of the information we have at our fingertips while also being aware of these tensions outlined above.

But in turn, so do the commissioners in respecting our right to have a view on behalf of our constituents, recognising our value in being able to contribute on an equal footing to the decision making and not as a lesser partner that doesn't have cost implications in monetary terms. Many VSOs are very well run businesses and our skills and expertise can come at a price, but with the balance always, of doing what is best for our community.

8. How do you see the CSS market evolving?

If CSUs continue to grow and work in areas where they are actually remote from the locality, organisations such as ours can add insight, knowledge and experience.

9. Do you have plans to enter into partnership arrangements with potential Lead Providers of CSS?

Not currently but we are open to ideas and suggestions. Our motives are about ensuring the stroke community is able to receive the treatment and support it needs. If operating differently is required we are a mature and credible organisation able to consider what is the best direction to take.

Biography

How does your career so far help you in working with the NHS?
Understanding and following how the NHS and local authorities think and operate certainly has helped. I have seen stroke treatment and services grow and change and improve beyond measure over the last ten years and have been proud to be part of that. That a stroke survivor lives a reasonable quality of life or does not die or become severely disabled continues to be considered an essential element of health and social care provision is the thing that drives me. If I am helping others on the commissioning side of the NHS to understand and recognise that, then my knowledge and experienced gained in the last 18 years has been worthwhile.

What attracted you to working in this area?
Recognising that there were possibilities in improving care early on in those 18 years and that we could make a difference with small resources meant that to keep going was worthwhile.

What do you enjoy doing outside of work?
I have a large family, with four daughters, their partners and nine grandchildren, who we try to see as often as we can. I long for my small Greek islands and Italian family holidays as often as we can afford, and in between, cook, garden, walk the dog and sometimes even have time to pay attention to my husband and drink nice wines and see friends.

Sue Ryder

Commissioning support services

Group medical director and interim director of health and social care: John Hughes

1. How have you supported commissioners in the past, and what is your potential CSS offering?

We offer commissioning support around our specialist areas of complex neurological care and end-of-life care through a culture of embedding learning and improving clinical quality. We support service redesign, evaluation, service user wider engagement and offer bespoke clinical quality advice, in terms of what that would look like when certain indicators are met.

For example, we have been providing evidence around need for non-cancer service design solutions. The most well known is probably our partnership for excellence and palliative support in Bedfordshire, where we work in partnership with 15 other organisations. It's been shortlisted for a health service journal award and it's been cited in the Social Care Institute for Excellence (SCIE) for best practice, the Department of Health end-of-life 4th annual report as well as a recent monitor publication looking at examples of how you can drive up quality. We co-designed services there with commissioners, and it was piloted over the last 18 months before being evaluated. The evaluation looked at the economic impact and outcomes for patients in terms of preferred palliative care and clinical quality markers, and it is now operational.

In measuring quality, we usually perform a deep-dive in each of the services by adopting a patient safety approach and using an outcomes framework. As well as the framework being aligned with national indicators of quality, such as the safety thermometer, we also add more person-centred items, taking on board things that are important to patients, such as feeling safe and staying as well as they can.

Patient engagement is one of our strengths and we pride ourselves in having wide access to feedback. We obtain feedback through a range of ways including via our own clinical quality team. We also peer review our services and gather clinical data through feedback from patients and their families. We also gain patient feedback through smaller local charities who have a lot of access to patient views, which can then be brought to the table when designing what patients want.

We could potentially support strategic planning around commissioning intentions. For example, the year before last, we launched our forgotten millions campaign which highlighted that neurological conditions were not really being included in the Joint Strategic Needs Assessment in the majority of local authorities, and this has now been flagged in commissioning support in a number of areas.

2. How is your business structured? How does CSSs fit into this?

The business is very much structured under two arms. So one arm is specialist neurological care, and the other is end-of-life specialist palliative care. Any commissioning support we provide would be under those headings really. We also have a range of community services as well.

We're lucky in Sue Ryder to have expertise from commissioners who have been within the NHS at senior level, and we also have people who are experts in clinical quality. If you combine that plus the workforce element in terms of voluntary contributions, it's a great combination of experience to bring forth to commissioners. For the external work we've done, we've pooled together a small team of people who are most appropriate for that work.

3. What is different about your organisation, and why should commissioning organisations come to you?

I'd say that what we can demonstrate is a very person-centred approach. We were the first charity to incorporate published recommendations from the Francis report. We have taken that very seriously and are leaders in that field of how to implement the relevant recommendations in the charity sector.

We can also contribute to an understanding of compassionate care on a very practical level. On the back of the Francis report, we were the first charity to have a reaching out programme to see what person-centred care is like on the ground. So we have different directors from the department of health and senior civil servants take up placements within our hospices and centres as a way of getting that service user feedback.

Having a strong policy arm within the charity, we'd also be able to advise and support commissioners in the nuances around some of the regulatory requirements around commissioning. For example, the charity commissions regulations don't quite align with monitor, so we would be able to support commissioners in navigating their way around that. Furthermore, being one of the largest providers nationally of end-of-life and specialist palliative care which cuts across frail elderly, emergency admissions etc, we could offer that provider perspective and understanding.

Facts and figures

Number of dedicated staff in the healthcare team: 20
Current CCG, CSU and other NHS customers: CCGs in areas where we operate including Yorkshire, Peterborough, Bedfordshire, Gloucestershire, Oxfordshire, Berkshire, Leeds; CSU customers are still in development; LA including East Riding of Yorkshire, Lancashire county council, Ipswich, Greater London; Bedford Hospital, Peterborough Hospital, Leeds Teaching Trust, Royal Berkshire Hospital, Cheltenham Hospital.
Percentage of income from NHS contracts: 60% of palliative care
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS. structural reforms: Non applicable
Service coverage/types of service provided: Specialist neurological care for complex conditions; end-of -life care and specialist palliative care; community care services to support dementia, isolation and supported living
Main competitors: Undisclosed

4. What is your policy regarding payment?
We would look at that on a case-by-case basis depending what support it was that we were providing and depending on the amount of support required. So if it's a big piece of work, clearly, we'd charge for that.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?
There's definitely still a phase of bedding down as some organisational memory has been lost with the changes. The integration and financial agenda is enormous and I think the voluntary sector has a key role in that integration agenda.

At the moment, it's a challenge for commissioners to think differently, and within the specifications of procuring services, so it's important to make sure that those things are included which opens up the market for VSOs. We can help by making our offering clear through measures such as this report. Furthermore, as a large provider, we can work with smaller charities in the local areas to help highlight what they too can offer and help prepare them for commissioning support. Health needs assessment are also an area where the voluntary sector can really add strength due to extended connections within local networks.

6. What partnerships or planned partnerships do you have?
We're in strategic partnership with the department of health and the voluntary organisations disability council. We work in partnership with umbrella bodies and also with help the hospices, the neurological alliance and other charities such as Marie Curie. We're also a partner of the pioneer programme for integrated care—we're very much a partnership open organisation.

7. What are the major challenges of working as a provider of CSSs?
There's an element of conflict of interest when you are a provider as well, and that's something we've looked at on a case-by-case basis. So if we were asked to provide commissioning support in an area where we wish to provide the services, we'd ask if there was a conflict of interest and how we'd go about managing that.

8. How do you see the CSS market evolving?
I think it's obviously going to evolve with a lead provider framework coming into play, so I think it's open for others to be on that framework and offers more opportunities for collaboration. The framework clearly presents opportunities for charities and other CSS providers.

9. Do you have plans to enter into partnership arrangements with potential lead providers of CSS?
It's not our highest priority at the moment with service provision being the core part of our business, but we would look at it if the opportunity arose. It's recognising that Sue Ryder are the experts in the field that we work, so if someone required commissioning support around those areas, we would be happy to hear from them.

Biography

How does your career so far help you in working with the NHS?
My clinical background is general practice and so I am well versed with the clinical challenges in the NHS and all too well aware of the structural changes which colleagues continue to experience. I have also been a medical director in a primary care trust and, before joining Sue Ryder, I was the medical director of a large NHS Community Trust.

What attracted you to working in this area?
I was attracted to the Sue Ryder charity because of its underlying ethos of high quality care for the most vulnerable of patients and because it has an exciting strategy for developing its end-of-life and neurological services.

What do you enjoy doing outside of work?
Gardening, bee keeping, fishing and travelling.

Turning Point

Commissioning support services

Director of strategic projects: Beverley Priest

1. How have you supported commissioners in the past, and what is your potential CSS offering?

One of the major ways that we have been supporting commissioners is through community engagement via a very rich, tried and tested model for research using our Connected Care tool. This can be as specialised as engaging diabetic patients in a particular ward or specific age groups within a borough, with the ability to further involve them in co-designing pathways.

Connected Care is both peer-led and community-led as the research is carried out by a team of local volunteers, often quite removed from the labour market, who we have trained up to NVQ standard. They then talk to their neighbours and members of the community, which in addition to community assets and resiliences that we've built-up in the local area, can often lead to the integration and redesign of services we facilitate to produce substantial cost benefits. Over the last five years, we've had a track record of engaging over 100,000 people across a variety of geographical areas and different conditions. Part of why this is so successful is because having carried it out so extensively, we're very good at tapping into what is needed, who we need to get on board and reaching out to local networks.

Within local authorities and clinical commissioning groups (CCGs), including Birmingham City council, Barnsley and Worcester CCG, a lot of the research which initially started out as a community engagement initiative has moved very quickly to us being commissioned to co-design and pilot services or to work with a local organisation to do so. For Dacorum, we are currently conducting research in to how the community would like to be supported (where appropriate) to use the council's online services; and by so doing, divert them from more costly face-to-face and telephone provision.

Another area we can support CCGs, which also draws on Connected Care is the strategic planning around tackling long-term conditions and how to interrupt the pathway.

Facts and figures

Number of dedicated staff in the healthcare team: 79
Current CCG, CSU and other NHS customers: For CSS this includes the Department of Health (Voluntary Sector Investment Programme); Camden CCG , West London CCG, South Worcestershire CCG, Great Yarmouth and Waveney Clinical Commissioning Group, Barnsley CCG, Birmingham CCG
Percentage of income from NHS contracts: Undisclosed
In percentage terms, approximate growth in 2013/14 healthcare revenue, if any, attributed to the latest NHS structural reforms: Non applicable
Service coverage/types of service provided: Commissioning support; primary care and wellbeing services; specialist and integrated services for substance misuse, learning disability, mental health; employment
Main competitors: Undisclosed

2. How is your business structured? How does CSSs fit into this?

We're best known as a service delivery organsation. We have specific business units for learning disabilities, substance misuse, employment, mental health and primary care under which we run general practice.

We also provide strategic support to NHS bodies and local authorities informed by the breadth of knowledge we have from straddling both markets and from insights obtained through Connected Care. Within Connected Care, there is a core team of seven senior researchers and project managers who each take a lead in supporting and training people recruited locally. So there is central control with people doing the work at a local level, and we can also draw on specialist services internally.

3. What is different about your organisations, and why should commissioning organisations come to you?

In a climate of integration and the better Care Fund where commissioners and CSUs are weaving the threads of building future services with local authorities, the fact that we run both NHS and local authorities contracts in our service delivery arm means that we have an understanding of both mentalities. Then specifically, within the Connected Care arena, having been commissioned by CCGs, primary care trusts, and local authorities, we can help commissioners to navigate services across the different contexts.

In Connected Care, through a pilot project commissioned by Birmingham City council, we have developed a new approach that is helping patients navigate health boundaries through getting the help they need across the health and social care system.

What we do in Connected Care is also directly relevant to commissioners as it can be linked to what they do on a local scale, building a very local perspective of what is needed, and going on to design and deliver a service around that. Connected Care is also embedded in our general practice in Earl's Court, where the services provided in the health and wellbeing centre originated, and benefit from our ongoing community engagement.

Our strength also lies in that while we are a national organisation, we are also deeply local as the people who carry out the ground work are recruited and trained locally.

4. What is your policy regarding payment?

Yes, we do charge.

5. What challenges do you feel NHS commissioners face? How do you believe CSSs, and in particular VSOs, can add value for them?

We are reaching the end of the beginning in the sense that with the massive upheaval, there is also great potential for change. With commissioners being tasked to do more for less money, there are clear financial challenges, but this should be a positive driver for change.

Where we can help is by filling in the gaps to what GPs already know, because while they may know their patients really well in one context, they don't always have the full picture as they don't know what happens when patients leave the consulting room.

The fact that CSS has now become a 'thing,' with a 'name,' shows that there is recognition that there are some areas where additional support is needed and where hopefully we can complete the jigsaw through more of a partnership than there has been in the past.

6. What partnerships or planned partnerships do you have?
Partnership is one of things that makes us successful across the board as an organization, and these include Apteligen who help with the cost benefit analysis for Birmingham Navigator Service, Start Here and NESTA (National Endowment for Science, Technology and the Arts). Additionally, we have local partnerships on each of our Connected Care projects. For example, in Worcester, we are commissioned jointly by the council and the CCG. We also have strong links with scores of local stakeholders, including NHS health and social care providers, housing providers, education venues, the police service, voluntary organisations and community centres.

7. What are the major challenges of working as a provider of CSSs?
Getting inside the heads of the people that need us! After a period of great change, understanding the context in which CCGs and CSUs are working really matters, which is difficult when the system is still so fragmented. From the outside looking in, CSUs provide such different services, so it's difficult to spot where to fit in.

We know there are people out there who need us and who ought to be using the stuff that we do, so one of the challenges we face is making it relevant and finding the right people to talk to.

8. How do you see the CSS market evolving?
If commissioners are going to succeed in commissioning better services for less, there needs to be a diverse CSS market as well as an openness and willingness to use the full breadth of services. Patients and communities can be part of that – we see ourselves enabling commissioners to work creatively alongside communities to result in services they want that will actually work.

The voluntary sector has supported commissioners in different ways for many years. If CSS providers in the voluntary sector can get the language right and navigate the current structures, the way is clear for a vibrant and diverse CS market to develop. In turn, this also paves the way for more of a real sense of partnership than there has been previously.

9. Do you have plans to enter into partnership arrangements with potential lead providers of CSS?
Yes, this is something that we've very keen to do and are looking into.

Biography

How does your career so far help you in working with the NHS?
I've been here for 11 years, and a senior strategic leader for the past eight. My background spans policy, communications and operations, so I blend my leadership experience with marketing and communications and piloting our new-style service delivery.

What attracted you to working in this area?
Creating new solutions that work for real people – patients and commissioners– in the face of national policy requirements and the demands of local delivery on the ground is what makes it so interesting. Also one of the biggest and most rewarding things comes from the legacy of transformation and confidence that results in local communities as part of engaging their views and their realisation that what they think matters. While the services that result are community assets, it's also a transformative process at a very human level.

What do you enjoy doing outside of work?
Having recently given up a smallholding of chickens and Highland cows, energies are, for now, concentrated on my young family and simple pursuits such as cooking, singing and dancing that don't involve muck or wellies (apart from jumping in muddy puddles).

DR Associates

Commissioning support services

Director: Dan Rixon

1. What CSSs will you provide over the next 12 months?

We provide a specialist transformation capability that facilitates health economies to work together to design and deliver better services and achieve improved health outcomes. We design and facilitate multi-stakeholder transformation events to engage health and social care and local authorities with commissioners to co-create service improvement or reconfiguration strategies and plans. Our approach generates very high levels of clinical and community engagement and leadership, and we have helped commissioners, clinicians and chief executives work together to implement a full spectrum of quality improvements and service transformations. We assist clinical commissioning groups (CCGs) to work with their stakeholders to:

- Create a vision for whole system transformation.
- Develop and implement commissioning strategies for service improvement or reconfiguration.
- Respond to national strategies or guidance such as NHS 111, the quest for quality in care homes or 3millionlives.

The high levels of collaboration and engagement in our transformation programmes significantly increase the level of integration and partnership in the health economies we work with. Clinicians have said that we build them the clinical momentum and voice they need to transform the system.

We aspire to help a commissioning support unit (CSU), a community or group of clinical commissioning groups (CCGs) and trusts to develop this capability as a transformation tool in their local health economies. We further believe some economies and CSUs would benefit from making this capability a strategic asset by developing a physical centre of excellence, such as the Innovation Center at the Vanderbilt Center for Better Health in Nashville USA. There the community and clinical leadership work in partnership with insight from best practice to improve health outcomes.

2. How is your business structured? How does CSSs fit into this?

We worked for one of the large independent providers of consultancy across the Department of Health (DH), strategic health authorities (SHAs), the primary care trusts (PCTs) and saw in the new system that local health economies, led by CCGs, were going to need to work together to deliver safer better services in a different, more integrated way at lower cost. We had a specialist capability that facilitated integration and partnership oriented working and would naturally improve outcomes. We knew at that point we had a proposition and created DR Associates. We are structured to offer our significantly experienced resources to a number of key clients who want to engage their economies in a collaborative way and potentially develop a partnership with us. We see ourselves more as collaborative workers than management consultants. Providing a collaborative transformation service that improves outcomes for CCGs and CSUs is key to our business premise.

3. What is different about your organisation, and why should commissioning organisations come to you?

The relationship between price, value and outcomes in our proposition is different to other providers. We have high levels of expertise and a powerful ability to influence leadership. We have an approach that generates enormous levels of engagement and commitment to succeed. We create a coalition across organisational boundaries focused on the patient and better outcomes. It makes any strategy easier and more cost-effective to implement. We have a team of facilitators that have delivered more than 60 significant whole system transformation or pathway improvement events in the NHS, social care and DH over recent years. These events, in particular, give CCGs and CSUs the opportunity to significantly engage their stakeholders and positively influence the quality of outcomes. They will also achieve them faster with less effort.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

Every CCG has to:

- Manage the tension between improving outcomes and managing cost and investment.

Facts and figures

Please specify the number of dedicated staff in the healthcare team: Five focusing on healthcare and an associate network of 50 facilitators and consultants
Who are your current CCG, CSU and other NHS customers: Cumbria CCG, Cumbria Northumberland Tyne and Wear Area Team, North of England Strategic Clinical Networks
What percentage of your income/work is from NHS contracts: 50%. We focus most of our business development on healthcare but work in other sectors if invited
In percentage terms, what is your approximate growth, if any, in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: Our work has been more focused on the normal evolution of quality of care and service issues. I see growth from the reforms in 2014/15 once the CSS market matures
Service coverage/types of service provided: Design and facilitation of transformation and engagement events, clinically driven outcome focused transformation programmes, pathway improvement, service redesign and configuration, design and leadership of healthcare transformation centres improving outcomes and integrating economies
Main competitors: We are competing against the major independent players, but our proposition is completely different

> Facilitate the delivery of integrated care.
> Transform patient care across organisational boundaries and CCG geographies.

The solution to each is common. They require the establishment of effective relationships at leadership level, partnerships between organisations and collaboration between clinicians and carers. These capabilities are not widespread currently and CSSs should evolve to support their development.

5. What partnerships or planned partnerships do you have?

We partner with Zero Tolerance Healthcare. They provide the skills and experience of the medical director and the chief executive, and have access to significant system and clinical leadership capabilities. We developed our partnership working together to influence clinical leaders to collaborate with commissioners to implement a clinically led vision improving the quality of health and social care in the North East. We created a clinical movement that focused on the patient and improved the quality of care in many pathways and redesigned and reconfigured more integrated services across organisational boundaries.

6. What are the major challenges of working as a provider of CSSs?

Our observation is that each CCG is different in practice. It is a fragmented market. They each have their own personality, demographic and geographic nuances. The quality of relationships across their health economies and with their neighbours varies too. This influences their vision and leadership style. A provider of CSSs therefore needs to be alert to the specific needs of each CCG, its leadership style and have an agile approach to work with local leaders to best influence local outcomes. We think this is going to require genuine healthcare transformation experience and high levels of consulting and coaching skill.

7. How do you see the CSS market evolving?

The CCGs will begin to seek increasingly greater levels of transformation as they pursue their visions with greater confidence. As the partnerships develop in their economies they will engage their communities and economies more to achieve bigger goals in more complex challenges. We see local leadership being the key driver of better outcomes. We see the CSSs market extending to support these leaders to be ever more successful as inspirational and effective leaders by providing more pervasive tools that maximise the influence they have on health outcomes and behaviours across health and social care.

8. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?

We have been following the development of this framework from the beginning from the perspective of a committed small medium enterprise. We plan to partner with CSUs and the major players in the independent sector. The independent sector is our heritage and we have both the service capability and healthcare experience that will be beneficial to the propositions of virtually all the future lead providers. We have a unique capability to get the organisations in any health economy to work together in partnership to deliver better integrated care. If a CSU could internally develop this capability, like the Vanderbilt Innovation Center and Center for Better Health in Nashville, they would develop a significant capability to facilitate the transformation of their economies.

Biography

How does your career so far help you in working with the NHS?

I started working in health about 10 years ago as a vice president in Capgemini and helped build the health sector there. I have worked on 50 different health projects over the years across a broad range of system management, whole system transformation and service and pathway redesign challenges. I have worked nationally and locally on the frontline issues. I developed my transformation skills on global shared services projects for American Express and the RAPID process improvement programme for Ford Motor Company. I have also built and run centres, like the Vanderbilt Center for Better Health,

What attracted you to working in this area?

Firstly, the fact that our work has a direct influence on the quality of a life in the future. I like to drive home on a Friday knowing that I have been part of a leadership team that has made a difference. I also believe that transforming the NHS is one of the toughest leadership and consulting challenges in the UK. I have worked on global transformation programmes in financial services, automotive, pharma, retail and consumer goods. They were all easier. I find, in healthcare, the importance of the work and the scale of the challenge a great draw.

What do you enjoy doing outside of work?

Surfing, skiing, mountain biking and supporting my two daughters in their own passions.

Eight Ninths Ltd

Commissioning support services

Director: Chris O'Gorman

1. What CSSs will you provide over the next 12 months?
We will be able to provide commissioning support services (CSSs) in the following areas: strategic and operational planning; service review; service reconfiguration advice, planning and programme management support; pathway redesign; business development; dispute resolution.

2. How is your business structured? How does CSSs fit into this?
Our business model is to create bespoke teams of associates around specific projects or programmes to meet a client's requirements and specifications. We provide services to health and social care providers, commissioners and infrastructure support agencies; CSS is an important part of our service portfolio.

3. What is different about your organisation, and why should commissioning organisations come to you?
We operate in a calm, methodical and measured way: we do not flap. We can therefore be trusted to operate effectively in highly pressured and sensitive circumstances. We can process and analyse complex, multi-source layers of information quickly and get to the heart of the matter: so we are efficient and effective, and accurate. We are interested in genuine transformation, and not in cliches or secondhand ideas. So we have a vision for the future of healthcare which is not about more of the same, but cheaper, but about new ways of shaping healthy communities and healthy ways of life.

We are influenced by systems thinking and psychodynamics, so we aim to change the eight ninths of the iceberg that is beneath the surface: so we don't just look at the transactional, but at the relational, psychological, spiritual and social dimensions of healthcare.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?
NHS commissioners face many challenges, and we can assist them in facing many of them. Healthcare systems are increasingly troubled by demand and, in some cases, by quality issues. Much healthcare continues to operate without a genuine customer focus. We can review systems and services in depth, engaging properly with patients and stakeholders. We can faciliate the development of strategic, operational and business plans which are built on the highest expectations of healthcare, and on the broadest understanding of what health and wellbeing mean. Health and social care services have to be purchased and provided against a background of increasing financial stringency: we can help services and systems reduce costs by transformation, not by a regime of cuts. Health commissioners are under intense pressure and are working extremely hard: we can make life easier and smoother by getting things right the first time, and producing high quality products quickly and efficiently.

5. What partnerships or planned partnerships do you have?
We are always looking to expand our pool of associates. We are exploring a number of opportunities to work as a partner company with larger organisations.

6. What are the major challenges of working as a provider of CSSs?
Control of the commissioning environment belongs primarily to CCGs, and then to NHS England. CSSs has a challenge in ensuring that CCGs and NHS England can achieve what they aim to achieve on behalf of patients.

7. How do you see the CSS market evolving?
We think it is unlikely that the current model of CSUs will remain the predominant model into the medium term. We think it more likely that there will be, on the one hand, networks of CSS providers from a range of sectors working through brokerage to CCGs and NHS England and on the other, we expect CCGs to increase the amount of commissioning support they bring in-house. We expect both of these developments to be complementary.

8. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?
Yes. We are looking to work in partnership with one or more CSS lead providers as we think this is most likely to be the shape of the CSS market in the future.

Facts and figures

Please specify the number of dedicated staff in the healthcare team: Up to 10 associates
Who are your current CCG, CSU and other NHS customers: Currently: The Pennine Acute Hospitals NHS Trust, Health Education North West
What percentage of your income/work is from NHS contracts: 90%.
In percentage terms, what is your approximate growth, if any, in 2013/14 healthcare revenue attributed to the latest NHS structural reforms? Not applicable
What is the service coverage/types of service provided? Eight Ninths Ltd primarily serves Greater Manchester, Lancashire and West Yorkshire. We provide high quality consultancy support in strategic and business planning, service and contract review, service reconfiguration, bid writing and content management, and dispute resolution.
Who are your main competitors? Other small and medium enterprises

Biography

How does your career so far help you in working with the NHS?
My career includes working in all three sectors. First in the voluntary sector, running both a council for voluntary service and a local mental health provider. I then worked in the NHS for 13 years, primarily as a commissioner - including the role of deputy managing director of a primary care trust (PCT) and subsequently as a provider - head of strategy in a major acute trust. I now own and run my own health and social care consultancy company.

What attracted you to working in this area?
I am interested in genuine transformation of communities and services. Running my own company gives me enormous opportunities to influence and shape transformation at a local level.

What do you enjoy doing outside of work?
Walking, the pipe organ (performance), wildlife conservation, military history.

Healthcare Commissioning Services Ltd

Commissioning support services

Director and co-founder: Roger Hymas

1. What CSSs will you provide over the next 12 months?

We start from the proposition that only effective, robust commissioning can save the NHS and we're convinced that, properly executed, commissioning should have prevented what occurred in NHS Mid Staffordshire Foundation Trust. There is a compelling need for the NHS commissioning to be delivered with the rigour and expertise we see in large companies such as Apple, Rolls Royce or Samsung; but arguably, even more so, because as a business the NHS in England is bigger than all of these.

This means that commissioning needs industrial grade systems and processes to meet this challenge. It has to understand how supply chains work; how enterprises struggle continuously to streamline their business processes; how a firm's communications with its customers should match and mesh with their life circumstances and lifestyles; why quality and customer satisfaction are so important and how the opportunities of new technology will fundamentally challenge the status quo.

We believe there is a compelling need for some old-fashioned 'Taylorism' to be introduced to transform NHS commissioning delivery. American, Frederick Winslow Taylor (1856 – 1915), a mechanical engineer, was one of the first management consultants. He worked on improving industrial efficiency and is regarded as the father of scientific management.

We see our challenge as working with the commissioning support services (CSSs) industry to find the one best way, to help clinical commissioning groups (CCGs) implement new standards of commissioning excellence and contribute to finding a secure future for the NHS.

2. How is your business structured? How does CSSs fit into this?

We established our company in 2010 to occupy a gap in the soon to be created CSSs market. We felt there was an opportunity for an organisation to perform an intermediary role, helping commissioning support units (CSUs) and other suppliers understand what CCGs require to deliver their vision and mandate. And for CCGs themselves to see what was on offer, and exactly where to find the best of breed systems and services for each of the separate functions of the commissioning cycle. We believed there was the need for someone to start acting as market maker. To that end we take part in health events and act as facilitator for CSSs.

This June, we'll return to the Commissioning Show and we will work on an agenda that will allow CSS providers to show what they have on offer as a consequence of their contributions to the lead provider framework initiative. We're not, per se, in the conference and exhibition market, it's just something we felt we had to do to stimulate a market in CSS services. We are fully signed up to the vital role of markets in reshaping industries and we will continue with our prime focus of undertaking assignments on behalf of single or groups of CCGs to help them procure the best CSSs.

3. What is different about your organisation, and why should commissioning organisations come to you?

We are the only independent organisation facing manufacturers, distributors and purchasers of CSSs. We have been described as a 'broker' and we are ready to live with this description. We provide a range of business benefits for CCGs, building on databases such as NHS England's Directory (nhs.clickymedia.co.uk/directory). We can help CCGs make more informed purchase decisions and work with CSUs and private sector providers to improve and customise their commissioning services. We can assist CCGs with the evaluations and procurement of their commissioning services, helping them continue to provide and develop the best possible services for their patients and public. We have worked with all but one of the CSUs which existed in summer 2013, as we brought them together at last year's Commissioning Show at Excel in the Commissioning Innovation Pavilion. We also organised the CSS conference agenda and have been retained for the 2014 Show. We have separately collaborated with a number of CSUs helping them source and develop commissioning business solutions.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

There is now a need to build momentum, enabling CCGs to be certain that they have secured the best available services to deliver an exceptional standard of commissioning. We think CCGs will be looking for the best solution, not the nearest one. In most cases, the 'cloud' will eliminate issues about time and distance. Our 'challenger' business model offers a different way of helping CCGs find the best commissioning services. Across all the components of the commissioning cycle, we will be encouraging the creation of exemplar solutions. At present, there is very little information available to CCGs about the comparative strength of services on offer from CSUs and the private sector.

We are ready to work with a CSU which is ready to 'flip' its business model. Instead of

Facts and figures

Please specify the number of dedicated staff in the healthcare team: 10
Who are your current CCG, CSU and other NHS customers: undisclosed
What percentage of your income/work is from NHS contracts: 100%
In percentage terms, what is your approximate growth, if any, in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: Significant growth on prior year, all from commissioning related assignments
What is the service coverage/types of service provided? The entire commissioning cycle as covered by the lead provider framework
Who are your main competitors: undisclosed

orienting itself to building and selling its own commissioning products to CCGs, the CSU would act as a procurement company, sourcing, customising and installing the best services available in the marketplace, irrespective of their origin. The core competences of this CSU would be product evaluation, bench testing, supplier negotiation and contracting.

5. What partnerships or planned partnerships do you have?

We work with all the major players in commissioning, including NHS England.We help new market entrants shape their offers to CSUs and CCGs. We collaborate with CSUs in the sourcing and development of their CS services. We are beginning to work on individual assignments for CCGs.

During the period 2005-10, we worked with upwards of 30 primary care trusts on a variety of commissioning projects, mostly through our association with Humana under the Framework for procuring external support for commissioners arrangement. We helped them become an end-to-end provider in a process arguably much more complex and demanding than the current lead provider framework. We are presently working with organisations which have outstanding solutions and we are ready to offer these up as 'challenger' products. We have links to the technology, management consulting and communications and advertising industries and to private equity.

6. What are the major challenges of working as a provider of CSSs?

CCGs are incredibly time poor, we can provide extra sets of hands. Our market knowledge is available to CCGs to help them find the best solutions. We see every assignment as different, as every one of the 211 CCGs is different. CSUs are going to cease to be-NHS owned entities in 2016. They might become social enterprises, not-for-profits or private sector companies. We are recommending CSUs offer outstanding, sector leading, products and services and source the solutions which offer maximum utility and best value, from wherever they exist in the market. It's critical that CSUs find their unique selling point. Unless they do this, we think in the long-term that there is the risk that CCGs are much more likely to assemble their own combination of best of breed vertical offers, rather than sign up for an inferior end-to-end offer.

7. How do you see the CSS market evolving?

We are suggesting that on their journey to autonomisation in 2016, CSUs might see a focus on a limited number of product categories, rather than be tempted into the harder to deliver, less differentiable, and more contestable option of the end-to-end solution. Also, CSUs who focus on product specific opportunities and maybe start to work with a specialist external provider, possibly in a joint venture, might have an easier to understand business model. Private equity investors look for investment opportunities which demonstrate a strong revenue stream, good margins, a difficult to replicate proposition, a sustainable product development trajectory and sound management. But there is an interesting question around how CSUs are going to reimburse HM Treasury for these £50 to £100 million turnover businesses which they are taking private; where is the replacement capital going to come from?

8. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?

Yes, we see ourselves engaged with partners in NHS commissioning across the lead provider framework. There are different strategic options for all of the players. Finding the right strategy for your organisation, whether you are buyer or seller, is critical. .

Biography

How does your career so far help you in working with the NHS?

I've been in the health sector for over 20 years. My first job as a commissioner was as managing director of Bupa, where I restructured a £1 billion acute care commissioning business which was then close to insolvency. I helped co-found Health Dialog in Boston, creating the world's largest disease management company and a New York based dotcom start-up serving the back offices of US GPs. From 2005 -10, I advised Humana, the large US health maintenance organization, on their NHS strategy and guided them through FESC. I helped more than 30 PCTs with World Class Commissioning assignments and was seconded to Hampshire PCT as Director of Commissioning. I founded the Commissioning Community with a Technology Strategy Board grant in 2009 and set up HCCS in 2010.

What attracted you to working in this area?

Prior to Bupa, I worked in senior management positions for the AA, American Express, the Burton Group and GE Capital. But nothing comes close to health care in terms of its complexity, and yes, worthiness.

What do you enjoy doing outside of work?

I pursue an eclectic range of interests but I've never had a hobby, so I'm master of none.

Hunter Healthcare

Commissioning support services

Partner: Damian Tatlow

1. What CSSs will you provide over the next 12 months?
Our proposition is to offer clinical commissioning groups (CCGs) and commissioning support units (CSUs) access to a tailored talent pool of specialist interim consultants that's handpicked to support the transformation of their local health and social care services. We have specifically invested in developing networks across some of the key hotspots of commissioning support services (CSSs) which include; strategy and planning, transformation, project and programme management, finance, quality, innovation, productivity and prevention (QIPP) and turnaround; provider performance and procurement; workforce and organisational development; communications and engagement; and clinical expertise to support change. This means we can put individuals or teams into an organisation to help them to develop a strategy for their area and to drive forward their transformation agenda. We can help our clients find executive talent on a substantive basis and as well as helping them to make non-executive and advisory board appointments as required. We also offer executive coaching and mentoring to help the leaders of the new NHS commissioning bodies to meet the challenges they are facing.

2. How is your business structured? How does CSSs fit into this?
The business is split into an executive search practice and an interim management and independent consulting practice. These businesses are supported by a research team. I lead on the NHS commissioning market and the CSS business is delivered by this team. This structure allows us to invest in research to map talent across a range of important skills sets for CSSs.

This investment in market intelligence allows us to identify and target only the highest calibre individuals to join our interim management network and independent consulting talent pool.

We take 360 feedback on a formal and informal basis to ensure that we are confident of the delivery track record and that we understand the style of the associates within the Hunter Healthcare network.

Facts and figures

Please specify the number of dedicated staff in the healthcare team: 10
Who are your current CCG, CSU and other NHS customers: They include CSUs, CCGs, and NHS trusts. We have also supported NHS Clinical Commissioners to offer developmental support to their CCG members
What percentage of your income/work is from NHS contracts: 85%
In percentage terms, what is your approximate growth, if any, in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: The business was founded in 2011; our turnover is projected to double year-on-year in 2013/14 and will reach £7m by the end of our third year of operation
Service coverage/types of service provided: Our offering is based on three unique service lines: Interim management network – we offer executive interim managers and change managers to help organisations drive through their improvement and transformation agenda. Talent pools of independent consultants – we provide individuals or small teams of people to offer bespoke strategic development, advisory and executive coaching services. Executive search – we run talent mapping, headhunting and advertising campaigns as well as a range of assessment services for executive and non-executive appointments
Main competitors: Larger and more established executive recruitment firms and in some instances the healthcare consulting firms

3. What is different about your organisation, and why should commissioning organisations come to you?
Hunter Healthcare was born from understanding the frustrations and costs associated with using the more typical recruitment businesses and consultancy models that exist within the NHS. Our vision was to offer a more flexible, cost-effective and healthcare focused model. Our offering to commissioning organisations is based on delivering bespoke resourcing support tailored to meet the challenging transformation agenda that commissioners need to drive.
It is unique in a number of ways as our NHS commissioning customers have a partner that: is exclusively specialised in the healthcare space with a team that truly understands the market that they are operating in and is specifically structured to focus on commissioning; is backed by an advisory board of NHS leaders, which in turn offers them access to extensive networks of healthcare management talent; is specifically focused on supporting commissioners to deliver high-value change by developing networks talent relevant to Lot 1 on the CSS lead provider framework; and invests heavily in research to identify, track and build relationships with the best senior management talent on the market.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?
The NHS is facing the most challenging period since it was formed. The population is living longer with multiple conditions and meanwhile, we have a financial envelope that is reducing in real terms. Transformation of health and social care services is critical to meeting these challenges. NHS commissioners therefore have a pivotal role to play in changing the way services are delivered across their local health economies to meet the future needs of their population. They also need to ensure that the quality of care they commission meets the high standards laid out by regulators. All of this is in the context of intense public scrutiny on patient safety and best use of taxpayer money. On top of these clear challenges, NHS commissioners

have recently reorganised into CCGs, CSUs and NHS England. Inevitably as part of this change there has been a loss of some of the corporate knowledge that would help commissioners to meet the challenges of the future, with many senior managers leaving the service. Hunter Healthcare was formed to provide NHS organisations access to senior management talent. There is a clear opportunity to offer flexible resource in a number of areas of CSSs and therefore allow commissioners to keep their fixed staff costs to a minimum. Essentially, we allow commissioners to buy in expertise for specific pieces of work that are relevant to what they need to deliver to meet their current or future commissioning intentions.

5. What partnerships or planned partnerships do you have?

We founded the business with an advisory board of NHS leaders to help us to shape our business model and our business plan. This includes: Mike Sobanja – former CEO of the NHS Alliance; Dame Ruth Carnell – former CEO of NHS London and Sir Ian Carruthers – former CEO of NHS South. We set the business up in partnership with the NHS Alliance and we have also forged links to NHS Clinical Commissioners as the new body that represent CCGs. We also have partnerships with the following businesses: CarnallFarrar – healthcare consultancy; iMPOWER – health and social care consultancy; Libera Partners – integrated care consultancy; Aldwych Partners – competition and procurement law consultancy; Alamac – health and social care performance improvement specialists; Talent Works – organisational development and cultural change specialists; The Faculty of Medical Leadershipand Management – specialists in advancing medical leadership.

6. What are the major challenges of working as a provider of CSSs?

The main one has been the change in the market. In some parts of the country CCGs are keen to engage directly to resource support of their commissioning and transformation priorities. In other parts the CSU is the main route into CCGs. There is still uncertainty in some areas about the future of organisations or some of their service lines and we expect to see consolidation in both the CCG and the CSU market. We have stayed close to our network to navigate this and grown gradually through reputation rather than making unsolicited approaches to each of the emerging NHS commissioning organisations. We have seen formal procurement processes by CSUs to select strategic resourcing partners to support the delivery of CSSs which is a time consuming exercise for a small business to respond to. Fortunately there seems to be an appetite from both CCGs and CSUs to engage with a newer player given the networks we give them access to and the niche focus of our business.

7. How do you see the CSS market evolving?

The NHS England lead provider framework should help improve the quality of CSS as the competitive market that this creates will mean it is easier for buyers to change their provider if the service isn't up to standard. This is challenging for CSUs who are in the process of becoming accustomed to operating in a more commercial fashion. It also presents a huge opportunity for the best ones to grow. As the market evolves, we expect to have a mix of CSU, CCG and NHS England customers.

8. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?

We are interested in working in partnership with a small number of the 'right' lead providers and are in conversations with some. We feel that we can help a lead provider make their proposition unique. Our focus on value and delivery is critical to organisations that are now selling their CSS to the market rather than being part of the same organisation in a primary care trust (PCT). The importance of CSUs protecting and enhancing their brand will be key to their success.

Biography

How does your career so far help you in working with the NHS?

I have a 12 year career in the recruitment industry which has included placing interim and change managers across the accountancy and financial services sectors. This has not only given me a strong background in growing high performing recruitment businesses but also enabled me to bring an understanding of how business works and how to help organisations deliver change.Some of the recruitment practices I've seen in the NHS are poor and I believe that educating our clients in the value of investing in a relationship puts all parties in a much better position to deliver.

What attracted you to working in this area?

In short the challenge. The challenge the NHS is facing and the opportunity to impact this by driving up the quality of senior resourcing within the sector. Then of course there is the personal challenge of building my network from scratch in a new market, having moved from financial services to healthcare in 2012. And finally there is the entrepreneurial challenge of turning our start-up business into the fastest growing executive resourcing business in the healthcare space.

What do you enjoy doing outside of work?

I play in and run an 11-a-side football team and I am avid skier and snowboarder – it's my ambition to go heli-skiing on my next trip to the mountains.

i5 Health

Commissioning support services

Managing director: Keith Davies

1. What CSSs will you provide over the next 12 months?
Clinical commissioning support in the form of: commissioning suite collaboration platform, information management, urgent care, invoice validation, services and conditions, risk management, contract management, demand management, risk assessment, risk stratification, and referral management service. Consultancy on non-medical prescribing, asthma, gynaecology, health analytics for planning and demand management (Joint strategic needs assessment, two or five year planning), quality, innovation productivity and prevention (QIPP), initiative modelling, predictive impact analysis, bespoke reporting such as effectiveness of primary and community services.

2. How is your business structured? How does CSSs fit into this?
i5 Health was created recently in anticipation of the reorganised NHS commissioning system and its aims and is structured accordingly. The executive team comprises a managing director, operations director and finance director. To address the CSSs set out in question one, the three executives and the six other professionals in the team have the following skill sets (in brackets are the number of individuals holding them): systems analyst (4), data quality analyst (4), patient pathway analysts (3), software programmer (4), website developer (2), SQL server developer (3), computer engineer (3), cloud computing engineer (2), health economist (2), project Manager (4). The multitasking that is reflected in the above reinforces the service levels of i5 Health.

3. What is different about your organisation, and why should commissioning organisations come to you?
We are probably unique in the level of its ability to link multiple data sets and generate, in real time, highly sophisticated commissioning support reports. Our cloud based commissioning suite platform provides a highly reliable and safer alternative for communication, cooperation and information management than currently exists for the NHS. Commissioners benefit from our long, creative experience (from both outside and within the health sector) of advanced analytics and algorithms which is applied in particular to invoice validation, risk stratification, quality, innovation, productivity and prevention (QIPP) initiatives evaluation and monitoring, detection of specialist commissioning and efficiency calculations for pathways (gynae, LTCs, cohorts, etc.) and initiatives (NMP, CotE, UCC, etc). i5 Health represents a culture of innovation that the NHS desperately needs. It is soundly based on both a high level of IT expertise and deep experience of the health sector and the NHS in particular.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?
The biggest challenges to commissioners include having to address greater and greater demand while depending on budgets that are, at most, static. This is as true for CSSs as it is for clinical services. CSSs must, accordingly, be continually upgraded and improved - in terms of technology and of the people providing them. Even as a new SME, i5 Health is investing in both (in the latter, inter alia, by funding for our associates to pursue PhD and Masters studies at Oxford University and Queen Mary University of London). i5 Health's CSS tools and services have already produced considerable and immediate value with the minimum of investment by commissioners.

These have been through, for instance, their ability to support local commissioning planning and the monitoring of clinical impact and outcomes, the organisation of information flows and data management and the processing of disparate data sources and schemas. Examples include referral facilitation service in Brent CCG, data analysis on non-medical prescribing for Health Education England, specialist commissioning misallocations analysis in respect of 50 most affected CCGs, risk assessment for NW London GP practices, urgent care modelling for Brighton and Sussex University Hospitals Trust (BSUH) and Sussex commissioners and Invoice validation for Brent and Kent CCGs. i5 Health's ability to demonstrate the value added nature of i5 Health's products and

Facts and figures

Please specify the number of dedicated staff in the healthcare team: Nine
Who are your current CCG, CSU and other NHS customers: Halton CCG, Ashford CCG, Canterbury and Coastal CCG, Brighton and Sussex University Hospital Trust, South Kent Coast CCG, Health Education England (to include all CCGs within North West England)
What percentage of your income/work is from NHS contracts: 90%
In percentage terms, what is your approximate growth, if any, in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: 100%
Service coverage/types of service provided: Clinical commissioning support in the form of: commissioning suite collaboration platform, information management, urgent care, invoice validation, services and conditions, risk management, contract management, demand management, risk assessment, risk stratification, referral management service. Consultancy on non-medical prescribing, asthma, gynaecology, health analytics for planning and demand management (JSNA, two or five year planning), quality, innovation productivity and prevention (QIPP) initiative modelling, predictive impact analysis, bespoke reporting e.g. effectiveness of primary and community services
Who are your main competitors: MedeAnalytics, Sollis, PwC, KPMG, E&Y, Deloitte

services attracted significant funding support from the Technology Strategy Board during our start-up phase.

5. What partnerships or planned partnerships do you have?
We have a formal partnership with HCCS and are in discussion with potential partners. These cannot be named at present because of strict non-disclosure agreements in force.

6. What are the major challenges of working as a provider of CSSs?
The current restructuring of the NHS is throwing up considerable challenges that include some CSUs not being stable organisations and CCGs that have yet to mature as managers of commissioning. In addition, information governance issues remain unresolved and put independent organisations like i5 Health as well as commissioners at a distinct disadvantage in respect of data.

7. How do you see the CSS market evolving?
We anticipate these issues in particular will be somewhat resolved during 2014. If that happens, we expect a rapid evolution of the CSS market, aided by the lead provider framework, over the next two years.

8. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?
We are meeting with a large CSU, which is a potential lead provider, to discuss this very matter.

Biography

How does your career so far help you in working with the NHS?
I have held senior leadership roles, including those of chairman and CEO, in multinational organisations within the financial services and health sectors. I led transformation of international insurance groups and banks. I was national director at the Department of Health (DH) creating and heading up programme for one third of NHS organisations that saved £1.4 billion in one year, of which 90% was annually recurring. I was managing director of health advisory practice of PwC (Canada) the clients for which were publicly funded health services of the Provinces. I headed up major health and finance projects in China, Australia, the Middle East, continental Europe, Ireland and North America.

What attracted you to working in this area?
Beyond my career in the finance sector, I have considerable experience in the Health sector in general and the NHS in particular. My role at the DH taught me not only the huge value of the NHS to this country but that it was significantly at risk. Without major innovation, the NHS cannot continue effectively to fulfil its national mandate. That innovation is as much needed in the CSSs as it is in the clinical domain. I and my colleagues saw the upcoming restructuring of the NHS as an opportunity to introduce much needed, ground breaking innovative solutions for CSSs.

What do you enjoy doing outside of work?
Being involved with my family, hiking in the mountains, reading and listening to classical music.

Ingenious Growth Ltd

Commissioning support services

Managing director: Chris Thomason

1. What CSSs will you provide over the next 12 months?
We provide support for innovative redesign of services at the strategic level, creating service blueprints at the tactical level and assistance with pilot deliveries of the new service.

2. How is your business structured? How does CSSs fit into this?
We are a small consultancy with deep skills in business innovation, service design and customer (patient) experience design. We have access to a broad network of skilled partners that enables us to supply the ideal team to meet the specific needs of the engagement.

3. What is different about your organisation, and why should commissioning organisations come to you?
The type and scale of issues faced by the NHS are such that applying standard best practices will often not be sufficient. We create innovative and appropriate service practices that are perfectly aligned to the identified needs and constraints. Services that improve the delivered quality and that create valued experiences for both patients and NHS staff. This is the core of what we do.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?
Commissioners may be challenged in identifying service scopes that are practically changeable to deliver value and quality without being too complex in nature. Obviously some issues will be complex and will inevitable need long-term approaches to address, but the vast majority will always offer the opportunity for shorter-term wins. The challenge will be in extracting these opportunities from out of the more complex issues so that some progress on improving the value and quality of service can be achieved.

5. What partnerships or planned partnerships do you have?
We currently have associations with two medical research and design companies who we have worked with several times in the past. They are Anatomy-HCD and award-winning designers PDD Limited.

6. What are the major challenges of working as a provider of CSSs?
The challenges will primarily be logistical in making sure that any discussions, workshops, meetings, co-creation sessions that are needed with multiple people can happen in a timely manner without noticeable disruption in the delivery of services in any way.

7. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?
We are flexible in our approach and willing to work with any lead partners where we can add value for them and ultimately to the CCGs.

Facts and figures

Please specify the number of dedicated staff in the healthcare team: Two, but this will flex as needed
Who are your current CCG, CSU and other NHS customers: None currently
What percentage of your income/work is from NHS contracts? Not applicable
In percentage terms, what is your approximate growth, if any, in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: Not applicable
Service coverage/types of service provided: Supply of professional consulting services in service design and re-design, patient experience development, process journey mapping, and innovative business problem solution design and execution.
Main competitors: Ideo, What If, LiveWork, Market Gravity

Biography

How does your career so far help you in working with the NHS?
I have worked in wide range of industries from automotive manufacture, deep level gold mining, precious metal refining, and the design and management of large-scale projects. I am a chartered engineer who did a MBA to develop deeper business knowledge.

What attracted you to working in this area?
When I bought an insolvent business I needed to make many changes to turn it around. Most were simply sound business practices but I started trying to find 'unusual' things to do to help the business grow. I didn't realise it at the time but this was the start of a deep interest in business innovation and a passion for creative thinking. This ultimately led me to becoming a full-time innovation consultant specialising in service innovation and an understanding that everything must incorporate great employee and customer experiences.

What do you enjoy doing outside of work?
I enjoy spending as much time as I can with my wife and child. I love running and am out most mornings very early on a run. I am also writing my first novel which is a neurological thriller!

iWantGreatCare

Founder: Dr Neil Bacon

1. What CSSs will you provide over the next 12 months?

Our offer is very clear – we aim to help our clients transform healthcare through large scale, real time patient experience feedback. iWantGreatCare (iWGC) develops and delivers solutions to capture and report high volumes of continuous patient feedback, providing a real-time 'smoke detector' for patient safety.

We provide a trusted and secure rate and review service and are also one of the largest providers of the Friends and Family Test to the NHS. Our vision is to harness the power of patient experience to transform care quality. To achieve this, we work with the NHS and independent commissioners and providers, developing and delivering bespoke solutions to capture and report high volumes of continuous patient feedback in real-time. We also work with organisations to report and share feedback to the widest possible audience, helping organisations to not only meet but also exceed their patient and public engagement requirements. Additionally, we provide a trusted and secure public service, which allows any patient or carer to rate and review individual GPs and hospital doctors on the care they provide.

Through iWantGreatCare.org, patients and carers can provide feedback on their care at any time, as well as review the honest and direct feedback of other patients looking for similar care. The age of the consumer has now reached the NHS and the patient voice is being put at the heart of decision-making. We expect this to trend to grow rapidly in the medium-term as patient feedback becomes an even more fundamental part of commissioning.

2.How is your business structured? How does CSSs fit into this?

iWGC was established in 2008 with the sole focus of bringing transformation to services through patient feedback. We have a dedicated team of 22 people and a group of associate advisors who have taken us to a market-leading position.

Our technical development team specialises in on-line and mobile solutions to allow easy access for patients giving feedback. Our account managers make sure that every roll out and new project goes smoothly. They also ensure that our management reporting systems to clients are optimised for their specific care setting – be that in acute hospitals, clinical commissioning groups (CCGs), community or mental health.

3. What is different about your organisation, and why should commissioning organisations come to you?

We provide patient feedback for health and social care only. Our systems are geared towards service and performance improvement and raising staff morale. All of our staff have extensive healthcare experience within the NHS and independent sectors. We focus on bringing results which health care professionals can understand and act upon.

We are not a generic market research organisation and we do not offer a 'survey' service. We believe real time data, gathered at a large scale, provide the best possible oversight of how systems perform and how people are treated.

We work to ensure each and every client has the system to suit their needs, regardless of the care setting. Our management information and public facing reviews give user-friendly graphical and text data for a holistic service. No other patient experience supplier offers such a trustworthy, transparent, independent and comprehensive solution.

We offer our service to commissioning support units (CSUs) at a heavily discounted rate which means whole health economies can benefit by adopting a cost effective, single standard solution. This allows for comparative benchmarking and ranking across organisational boundaries.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs, can add value for them?

The Francis Report and the Government's Friends and Family Test (FFT) have opened up health care decision-making to public scrutiny. CCGs have a responsibility to ensure primary care improvements and to buy services on behalf of their populations. They will be expected to listen and engage with patients, families and carers in a proactive way. This means systematising approaches to gathering patient feedback on a large scale in a way that shows a direct relationship between patient experience and commissioning.

Progressive CCGs have already started this process and aim to have patient experience as a contractual metric as soon as practicable. Others are just beginning to look at how to optimise their patient involvement in service alignment and delivery.

CSUs are in a prime position to be able to offer a patient experience service, which covers multiple care and organisational settings through providing data analytical and business intelligence services to CCGs. iWGC believes its automated information service would make a valuable and attractive addition to the standard suite of data management.

Facts and figures

Please specify the number of dedicated staff in the healthcare team: 20
Who are your current CCG, CSU and other NHS customers: Cumbria CCG, 40 NHS acute trusts
What percentage of your income/work is from NHS contracts: 80%
In percentage terms, what is your approximate growth, if any, in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: 100%
Service coverage/types of service provided: Large scale, real time, multi-channel, independent patient experience feedback system
Who are your main competitors: undisclosed

5. What partnerships or planned partnerships do you have?
We are currently working at the leading edge of whole system patient experience with Cumbria CCG and are likely to add several others to our client base. We have developed a robust and powerful acute service which reports huge increases in staff morale and service development. iWGC has also played a major role in helping NHS England develop the question sets for the FFTs. We are currently offering the FFT service free to GPs who sign up before April 2014. Our broader network includes other CCGs and practice manager networks. We also provide a service to Virgin Healthcare across England. Our service is also used internationally in 18 other countries by Diaverum, the dialysis provider and we are supporting four hospitals in New York.

6. What are the major challenges of working as a provider of CSSs?
To transform care, CCGs will need to embrace the patient voice. They will need to demonstrate that they have taken it into account in commissioning and decommissioning services. While many have developed committees and groups with whom they liaise, few have thought about large scale engagement.

7. How do you see the CSS market evolving?
The opportunity to understand patient experience across whole pathways is compelling. It will help commissioners to smooth 'transition gaps' between organisations and provide a tangible evidence base for when things go wrong or start to go wrong. That gives invaluable oversight into where corrective actions can be incentivised and true partnership working can be established.

8: Do you have plans to enter into partnership arrangements with potential Lead Providers of CSSs?
iWantGreatCare has a small number of collaborative arrangements with other major providers of CSU and CCG services. We are happy to work in partnership within a prime or alliance model but will still have a combination of partnering with CSUs and direct provision to CCGs.

Biography

How does your career so far help you in working with the NHS?
I worked as a nephrologist in the NHS and also the USA and then launched Doctors.net, the largest online community of doctors in the UK.

What attracted you to working in this area?
I believe patient feedback, at an industrial scale, will transform healthcare.

What do you enjoy doing outside of work?
I have a teenage son and a daughter, so family pleasurably takes up my spare time.

myClinicalOutcomes

Commissioning support services

Co-founder: Tim Williams

1. What CSSs will you provide over the next 12 months?
CCGs are starting to commission around a value-based healthcare model, where services are oriented around the patient and their medical condition and a whole cycle view is taken on care provision.

This is underpinned by contracts which incentivise outcomes that matter to patients receiving care rather than volume delivered. Part of doing this effectively is to define the right outcomes for relevant patient segments and then to introduce a mechanism for measuring them, which we do using innovative measures and systems-based methods to collect information directly from the patient.

Built to support follow-up for patients with long-term conditions, or for those who require intermittent post-operative review, we can query patients about their health status regularly over the entire care cycle, provide information about what the data means and information about other similar patients and local services, all of which are key to long-term engagement and an understanding of quality of care.

The data, which may include national survey data, such as for the national patient reported outcomes measures (PROMs) programme or Friends and Family Test, as well as local patient satisfaction information, can then be combined with existing process and performance measures to configure a deep understanding of care quality.

2. How is your business structured? How does CSSs fit into this?
We were originally developed to meet the needs of NHS orthopaedic surgeons in the South West who were frustrated that they could not follow-up patients after surgery for as long as British Orthopaedic Association guidance suggested. myClinicalOutcomes was a collaboration between clinicians and management consultants with experience of working in the NHS and with implementing new technology.

We brought development capabilities in-house very early and remain a small company determined to focus on delivering our core system well, rather than diversifying or 'building to order'. We emphasise the need for effective up-front local training over lengthy support contracts, understanding that technology needs to be embedded around existing workflows to work as intended.

Our aims is that the system meets the growing need of providers and commissioners to segment patient groups by demographic, condition and stage of treatment by asking pre-defined question set at intervals depending on these criteria, with information reported to these groups, as well as their teams and commissioners.

3. What is different about your organisation, and why should commissioning organisations come to you?
myClinicalOutcomes' mission is to help maximise value delivered to NHS patients. Co-founded in 2011 by NHS trained doctor brothers, one of the co-founders remains a practicing orthopaedic consultant surgeon; the other followed four years of practice with three years as a management and technology consultant to the NHS and other industries. The mixed experience of our team brings an appreciation for why it is all too often so challenging to innovate in the NHS, especially where information technology is concerned.

We understand that the procurement of appropriate technology is often left to non-clinicians driven primarily by cost and that as such the solution often provides only limited clinical benefit. Our 'lean' development model has meant that it remains highly cost-effective to deploy at scale.

As clinicians, we have been able to stay ahead of emerging needs, both from a clinical and a commissioning and policy perspective. As well as now fitting in with the revalidation requirements of clinicians and national surveying requirements of managers, we have created a system that can support the needs of commissioners in implementing a value-based approach to commissioning.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?
Commissioners need to organise their local services to drive improved patient outcomes in an increasingly cost-pressured environment. We believe the only effective way to do this in the long-term is by adopting a value-based approach to commissioning service; that is to organise around the clinical condition, measuring outcomes and costs for all patients, focusing on the extent to which services are addressing outcomes that matter to them.

Facts and figures

Please specify the number of dedicated staff in the healthcare team: Total team of five, three are currently dedicated to healthcare providers and commissioners
Who are your current CCG, CSU and other NHS customers: We have recently started projects with two clinical commissioning groups, and have relationships with several NHS providers including Royal Cornwall Hospital, Royal Devon & Exeter Hospital and, more recently, Barts Health
What percentage of your income/work is from NHS contracts: As of Jan 2014, approx. 30%. (rest split between UK independent sector and industry)
In percentage terms, what is your approximate growth, if any, in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: About 50%
Service coverage/types of service provided: myClinicalOutcomes is a patient-reported data outcomes data collection system, which reports real-time and at an aggregated level to clinicians, GPs, managers and commissioners, depending on local requirements
Main competitors: Undisclosed

Furthermore, payment bundles to incentise all providers who contribute to the cycle of care to work together to maximise value for the patient should be created. While all patients are different, it is possible to segment populations according to needs, and then to co-define outcome sets with those segments and to collect data longitudinally from them to understand and compare the impact that services are having to a) effect improvement, and b) incentivise ongoing improvement through contracting levers.

5. What partnerships or planned partnerships do you have?

As well as our NHS user base we have also been working with the private sector, with projects established at HCA International and planned at Nuffield Health, as well as with industry with a project under way with Zimmer.

We have been working with the newly established Private Healthcare Information Network (PHIN) as they begin to help the private sector meet the expected requirements of the imminent release of the Competition Commission's report, that is in the first instance to produce provider-level quality data which is at least as rich as the NHS.

6. What are the major challenges of working as a provider of CSSs?

An historic challenge for us has been in identifying relevant stakeholders and we have occasionally struggled to navigate through traditional NHS procurement hoops and to articulate the imperative to adopt our approach with any urgency.

In the last six months, the need for greater transparency and the benefits of data in driving care quality has moved on, not least for outcomes data in furthering the value agenda. As first movers, such as Bedfordshire, Oxford and CCGs across North London start to implement these new outcomes-based approaches, others seem to be keen to engage.

7. How do you see the CSSs market evolving?

I see business intelligence increasingly being incorporated into commissioning support and provisions for integrated care. In turn, technological developments tailored to meet those needs will be key.

8. Do you have plans to enter into partnership arrangements with potential lead providers of CSS?

Potentially; talks with several are underway.

Biography

How does your career so far help you in working with the NHS?

I trained as a doctor at Oxford University and Kings College London and worked in a variety of settings until 2008. I planned a brief sabbatical in management prior to specialist clinical training but found working as a management consultant with a clinical background in a variety of roles in the NHS and other sectors quite enlightening and instead have forged a career combining the two aspects. I deferred a Masters at Harvard School of Public Health in 2011 to focus on myClinicalOutcomes which had started as a side project but which quickly gained momentum. I also have an interest in NHS policy and systems and was selected for Prof. Michael Porter's Value-Based Healthcare seminar at Harvard Business School in January 2014, a concept which I believe will become increasingly important to the organisation of the NHS.

What attracted you to working in this area?

Running a health technology startup is attractive essentially because of the opportunity to make an impact on patient care and, importantly, healthcare costs; also poor IT is as ubiquitous in the NHS as the frustration felt by those who have to use it and their assumption that things can never change. Our lean company structure means that we can be quite nimble in developing and releasing useful new features. The niche we are focussed on is attractive because we are forging a new path just as there is an increasingly pressured need for it in order to drive value.

What do you enjoy doing outside of work?

I'm from Wales, so living and working in central London means that leisure time is all about escaping the rat-race. I enjoy running and cycling. My wife's from Sydney so we try to save for a trip out there to see her family once a year to escape the winter gloom!

Outcomes Based Healthcare

Commissioning support services

Founder: Dr Rupert Dunbar-Rees

1. What CSSs will you provide over the next 12 months?

Outcomes Based Healthcare (OBH) supports the adoption of outcomes and value-based approaches to commissioning. We work with healthcare providers, commissioners and patients who wish to define outcomes which matter to people, organising processes of care around them. Our work is underpinned by providing education and undertaking academic research into value-based healthcare. A core part of our educational work involves teaching UK and International Harvard Business School cases on value-based healthcare.

Rising healthcare costs, profound demographic change and increasing healthcare complexity are putting an unprecedented strain on the NHS. Rather than changes with a short-term impact, our organisation goes to the root of the purpose of care systems.

In line with the central principles of any value-based health system, we currently support health systems to:

- Co-define outcomes for people with similar needs.
- Determine appropriate measures for those outcomes.
- Evaluate contractual incentives for whole pathway outcome measurement across multiple providers.
- Understand whole pathway costing and payment.

We believe that supporting the spread of outcomes based approaches most effectively requires us to only get involved where we can add most value.

2. How is your business structured? How does CSSs fit into this?

OBH was formed in 2013, with the sole focus of assisting the development of outcomes based approaches to healthcare. We are based in The King's Fund Health Campus, London.

As a relatively new enterprise, we have a core team of five, each with diverse and complimentary backgrounds. Most have clinical backgrounds with varying degrees of experience and specialisms. Many have additional training and experience in business, finance, consulting or computing, as well as having completed the value-based healthcare delivery Intensive Seminars at Harvard Business School.

In addition, we work with a number of experts and innovators in the field of outcomes based healthcare, with deep practical and/or academic expertise in one or more of the more technical areas of this approach. For example: segmentation, health outcomes, payment systems, co-production, contracting for outcomes, PROMs (patient reported outcomes measures), outcomes measurement, outcomes data models. With outcomes-based contracting really only working when a whole system approach is taken, we work across the whole health system as well as with commissioning organisations.

3. What is different about your organisation, and why should commissioning organisations come to you?

There is no doubt that measuring outcomes and contracting on this basis is the direction of travel not only within the NHS, but globally in healthcare. Although outcomes have been at the centre of discussions for a few years, as a system we're still largely using the wrong unit of analysis by measuring outcomes by providers instead of around the person for the entirety of their care. We work with people who want to genuinely build a system where care fits around people, rather than the other way around.

Besides a 'hands-on' approach in co-producing and co-defining health outcomes and advising on the creation of value-based systems, OBH has a firm focus on education, facilitation and mentoring. This helps lay the foundations necessary to understand the importance of investing time in thinking about outcomes in a completely different way. With OBH there is no 'hard sell'- we have absolutely no interest in offering support that could be more effectively delivered in a different way. Success for us is measured by care being delivered routinely around outcomes agreed with people who use those services. We're also quite fun to work with!

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

NHS commissioners often find themselves in an incredibly difficult position of having to improve patient outcomes in a context of tight budgets and huge demand pressures. Many are reaching out to organisations like us to help them think through radically different options as the status quo is increasingly

Facts and figures

Please specify the number of dedicated staff in the healthcare team: Five
Who are your current CCG, CSU and other NHS customers: A number of CCGs and providers who are leading the way on outcomes and value-based commissioning. Ventures include the North Central London value-based commissioning project, which focuses on outcomes for three distinct population segments. Over the last year, we've worked with around 15 different NHS organisations
What percentage of your income/work is from NHS contracts: 100%
In percentage terms, what is your approximate growth, if any, in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: Not applicable
Service coverage/types of service provided: Co-production of patient-centred and patient-defined outcomes measures; outcomes data architecture; design of incentive and contract structure for providers to deliver that service; education, case-based teaching on Value and outcomes; facilitation, quality assurance and mentoring on value and outcomes
Main competitors: Undisclosed

not sustainable. They are often forced to commission and pay for services in traditional 'silos' of care, mainly because that is the way the system has evolved, and yet, people's health needs increasingly don't fit those organisational boundaries.

We believe commissioning support services (CSSS) of all kinds can help inform, define and implement different ways of thinking about care that genuinely spans organisations, and that can be commissioned for together. CSSs can also help commissioners measure the things which are important to patients. In our area of the market that means going beyond whether the care happened or not, to find out whether the care actually made a difference to people's lives.

5. What partnerships or planned partnerships do you have? Who does your network include?

We collaborate with a number of associates and strategic partner organisations, such as Capgemini, Beacon UK, BDO, and partner legal firms. We also have a number of ongoing discussions with a range of potential partners such as CSUs and outcomes and costing technology companies. Given our focus on teaching and education, we are also exploring formal affiliation with relevant academic institutions.

6. What are the major challenges of working as a provider of CSSs?

Encouraging a culture to not fear change, being open to change, ensuring consistency in direction between all those involved, and not being afraid to try. For outcomes based contracting, this usually involves working to generate a level of trust between partners who currently see themselves as quite different organisations. In terms of technical challenges, because of the niche we operate in, we also have some interesting conversations about what outcomes are, and whose outcomes we are talking about.

7. How do you see the CSS market evolving?

I hope to see the market open to innovation and change with strategies being employed from different industries and countries. If we start to look at international and UK examples of how value is being brought into healthcare systems, there are many lessons that can be learnt and I believe there is a real desire for change. There is bound to be a lot of turbulence and change as the CSS market is currently immature, but this is a fantastic opportunity to take stock of what commissioners, and ultimately patients, really want to know.

8. Do you have plans to enter into partnership arrangements with potential lead providers of CSS?

We are planning to work with a small number of lead provider organisations looking to specialise in outcomes-based commissioning.

Biography

How does your career so far help you in working with the NHS?

Having trained originally as a GP, I know how well the NHS works at its best, and how frustrating it can be for patients when it doesn't work so well. In the type of work we do, a clinical background can be a help and a hindrance though, as it's all too easy to assume that only clinicians know what a good outcome is, when actually the only person who really knows is the person receiving care.

What attracted you to working in this area?

I've always absolutely loved trying to do my best for the patient in front of me, and provide personalised care. But like many clinicians, that was usually in spite of the system, rather than because of the system. The NHS has done wonderful things for people since it was created, but it has to change from a system based around providers of care, to one which is built around the people who receive care. I believe that making a sustainable NHS requires people who have experience of delivering clinical care, as well as exposure to the realities of commercial world. This is what led me to retrain in finance and strategy half way through my career, and ultimately to what I do now.

What do you enjoy doing outside of work?

The sensible answer to that question is that I enjoy writing, when I get a chance. I also have a slightly more unusual hobby of travelling 'light' starting a few years ago, as I was frustrated with getting my things stolen in weird places around the world. This has somehow evolved into 'bagless' travelling, with just money and a passport, which is much more fun than it sounds!

Pulse Informatics

Commissioning support services

Managing director: Ravi Pattani

1. What CSSs will you provide over the next 12 months?
We hope to provide clinical commissioning groups (CCGs) and commissioning support units (CSUs) with services that will support provider management, the commissioning cycle, along with general business intelligence support.

In particular, we want to help commissioners regain financial control now that the restriction on invoice validation has been lifted. NHS England has advised CCGs that payments "should be limited to historical contract values... and are subject to retrospective validation and potential adjustment, once the new data flows have been established". Therefore, there will be a huge backlog of invoices for CCGs/CSUs to validate. It is imperative that preparations begin in earnest to:

- Avoid any unnecessary overpayments.
- Prevent resource bottlenecks.
- Maintain the momentum going forward.

We are offering a one-off service to allow CCGs to clear this backlog. Although invoice validation is our primary service, we can also help with day-to-day, information analysis tasks such as Secondary Uses Services (SUS)/ Service Level Agreement Manager (SLAM) reconciliations, individual funding request monitoring, benchmarking and provider trend analysis. These are the ground level tasks that CCGs and CSUs really value and are core to effective commissioning and decision support.

2. How is your business structured? How does CSSs fit into this?
Being a small company, we don't have an organisational structure as such. Essentially we are a team of experts who have worked in frontline healthcare analytics across a range of settings from commissioning to acute to mental health and patient administration system (PAS) software vendors. Within these settings we have held positions that range from project manager to standard query language (SQL) developer. This breadth of experience is underpinned by a genuine passion for healthcare informatics.

Facts and figures

Number of dedicated staff in the healthcare team: Two
Current CCG, CSU and other NHS customers: Our primary offering is an invoice validation solution so any potential customers have been unable to procure our services because of restrictions in processing patient confidential data (PCD). With these restrictions being lifted in December 2013, we have started to engage with clients. Before the creation of CCGs, our customers included Luton and Bexley primary care trust
Percentage of income/work from NHS contract: 100%
Approximate growth in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: All of our growth in this financial year will be attributed to the NHS structural reforms because our clients are CCGs and CSUs
Service coverage/types of service provided: We are a healthcare informatics company supplying commissioners with business intelligence - our specialism is invoice validation. As a start-up focusing on a relatively niche service we have been able to bring fresh ideas and develop a bespoke platform designed around the new NHS that really meets the needs of commissioners while addressing the new information governance guidelines. This is a key intelligence requirement and we pride ourselves on our ability to provide high quality information to support more effective commissioning
Main competitors: Undisclosed

3. What is different about your organisation, and why should commissioning organisations come to you?
As a smaller company we can be nimble in addressing the needs of today's changing NHS. This allows us greater flexibility and enables us to better integrate into clients' existing systems.

We also take an innovative approach to bring fresh new ideas to the informatics space. We place a greater focus on the user experience therefore providing a more efficient interaction with users. Having extensive experience working in frontline commissioning teams, we have a deep understanding of how the commissioning cycle works. Our offerings have been designed wholly around the commissioning cycle.

Furthermore, we have chosen to focus on a specific area of the market space in order to provide a more specialist, far superior product. Our invoice validation product is testament to our approach by going beyond the standard functionality of invoice validation (IV) systems. The core of the product is a rich informatics platform that enables CCGs to generate savings, allowing them to design services more efficiently. This is a critical issue for CCGs at a time when the NHS is required to meet stringent efficiency and budgetary targets. However, we believe that an IV solution should not stop there. A large amount of resource is spent in the reconciliation process after challenges are sent.

Our product provides a collaborative platform that allows GPs, CCGs, CSUs and providers to perform this reconciliation in real time. Challenges can be tracked all the way to the bottom-line, allowing commissioners to close the loop and make hard savings – this is unique among invoice validation solutions. Another differentiator as a result of our size is value for money - we don't have the costly overheads of larger providers and ultimately represent the best value to the taxpayer.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?
The issues that CCGs are facing are the same

issues that primary care trusts (PCTs) faced - namely, how to improve quality and patient outcomes with increased demand on the health system while trying to find efficiency savings of £20 billion by 2015. CCGs have inherited these efficiency targets from PCTs and should embrace this challenge, but they can only do this with the right support.

That means improving commissioning decisions by delivering better intelligence to GPs. As GPs assume commissioning responsibilities, they require enhanced levels of intelligence to perform their roles. This includes benchmarking providers, measuring delivery against plan and identifying cost pressures. It also means bridging the disconnect between GPs and providers.

Previously, most dialogue with providers was performed by PCTs, with GPs being further removed. In the new model, GPs will need to communicate directly with providers at patient level to better manage their care. These are the kind of healthcare challenges that Pulse Informatics can address. With the recent 'strategic mergers' of CSUs resulting in further redundancies, independent sector providers will play a more prominent role in providing CSSs to commissioners.

5. What partnerships or planned partnerships do you have?

Currently we do not have any partnerships with other companies, however we are in talks with a number of CSUs and independent commissioning support providers that have specific product gaps. We understand the evolution of the marketplace and are open to partnering up with other organisations.

6. What are the major challenges of working as a provider of CSSs?

As an independent provider of commissioning support services, one of the major challenges is around ever-changing guidance, and specifically in our case, information governance.

We have had to very quickly adapt and adhere to the latest rules, which is also something that commissioners have had to do. However this has made us really think about offering something that makes life easier for commissioners, e.g. having role-based access control that ensures people only see the data they need to and nothing more.

7. How do you see the CSS market evolving?

I believe that independent sector providers will play a more prominent role with commissioners going to smaller, niche organisations that exclusively offer a narrowly defined service, but do it better than organisations that offer everything.

8. Do you have plans to enter into partnership arrangements with potential lead providers of CSS?

Yes, we have attended the lead provider framework consultations from the beginning and aim to become a sub-contractor to lead providers. In fact, during the most recent workshop it was mentioned that NHS England would be hosting an expo for SMEs bidding to become sub-contractors, which is something that we will definitely be attending.

Biography

How does your career so far help you in working with the NHS?

I have worked in or for the NHS for the last 10 years. Having begun my career working for a consultancy on the National Programme for IT, I moved on to working for PAS software companies in various roles, all related to information analysis and business intelligence. The latter part of my career was spent working on frontline commissioning, encompassing everything from contract management and provider performance to bespoke data studies to improve pathway optimisation, before starting Pulse Informatics in 2011.

What attracted you to working in this area?

Commissioning is that it is a field where you can really observe how change can affect patient outcomes for the better. You are in the unique position of having a 360 view of the health system and can really begin to appreciate the challenges as well as the benefits, and that's why I started Pulse Informatics.

What do you enjoy doing outside of work?

Going to the gym, travelling and watching Arsenal football club.

Sollis

Commissioning support services

Managing director: Nigel Sloane

1. What CSSs will you provide over the next 12 months?
As a small to medium enterprise (SME) providing healthcare intelligence solutions to commissioners, we will continue to provide our existing software suites and allied professional services.

Our commissioning intelligence solutions currently support the areas listed below (see facts and figures). We serve both the transactional and transformational aspects of commissioning. Transactional processes are important and complex, and we will continue to deliver data management, analytics and business intelligence solutions that add value in this space. Increasingly, our focus is on commissioning intelligence as an enabler for transformational commissioning.

We are particularly interested in the emerging attention on value-based healthcare and outcomes-based commissioning. We will continue to invest in innovative software and professional services offerings that add value to these agendas, mindful that the new commissioning paradigm must concern itself with the measurement of outcomes that matter to patients.

Over the next year we'll be introducing a range of new commissioning modules and tools. We anticipate data management and analytical solutions to help commissioners transition away from payment by tesults (PbR) based contracts to more outcome-based contracting and commissioning approaches will be in demand.

Our offering will also be extended to support social care data and services, and as part of this we will also provide a stronger integrated care offering. Recognising the need to systematically support the lead provider framework we will also increase our existing capability to operate 'at scale' in the marketplace. Fundamentally, we will continue to listen and align our solutions with the needs of clinical commissioning groups (CCGs) and commissioning support units (CSUs).

2. How is your business structured? How does CSSs fit into this?
We are a privately owned company, organised around a relatively flat structure. Internally, we have two main groups - one focused on new applications development, the other on customer services and the exploitation of our commissioning analytics. We often use matrix techniques, combining specialists from both groups to solve business problems and deliver effective and agile solutions. Sollis personnel work closely with NHS commissioners to ensure our product and service offerings are aligned with their needs.

3. What is different about your organisation, and why should commissioning organisations come to you?
Many Sollis employees are ex-NHS, and we look to work closely with NHS organisations. As such, our customers know that they are partnering with a company who 'gets' healthcare and shares NHS core values.

Our solutions are typically hosted by the NHS and operated by NHS specialists. They are also open to working with local intelligence solutions, in an ecology of systems. In this way we give control to local organisations and specialists. We believe our collaboration with the world renowned Johns Hopkins University enables us to offer to the market a unique commissioning intelligence offering.

Our value proposition is 'Together: Putting you in control'. This is a key differentiator for Sollis, centered on a deep knowledge and understanding of the NHS domain and healthcare commissioning in particular. Ours is more than a simple technology offering. While our software and services include the delivery of business intelligence (BI), we are acutely aware that the real value of any BI offering is not to be found in the software alone. We believe its true value is to be found in

Facts and figures

Number of dedicated staff in the healthcare team: 26
Current CCG, CSU and other NHS customers:
- South London CSU
- Central Southern CSU
- South CSU
- North East London CSU
- Central Eastern CSU

We support 'customer' CCGs through the CSUs. We also support around half a dozen CCGs directly or through other commercial providers. Through this combination of channels, we support well over fifty CCGs across England. We also work with a Welsh Health Board and a few NHS providers

Percentage of your income/work from NHS contracts: 100%
Approximate growth in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: Undisclosed
Service coverage/types of service provided: Sollis provide healthcare intelligence software, data management, analytics and related consultancy services to commissioners. In software terms , our service could be called business intelligence, but we prefer the term commissioning intelligence and we see an important distinction. Our commissioning intelligence applications cover a range of solutions which can be broadly categorised as: Contract management and monitoring: performance management; risk stratification; predictive modeling: case finding; population profiling; and resource utilisation. We also offer a range of support and consultancy services and undertake bespoke developments to meet specific local needs
Main competitors: Undisclosed

the quality of decision making by CCGs where these decisions result in transformational change that creates a better outcome experience for patients.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?
At one level, the challenge for commissioners is the same as the challenge for the service as a whole – how to deliver healthcare in support of an ageing population while reducing funds and maintaining and improving standards of quality and safety. This requires specialist understanding and experience, and CSSs can support commissioners through at-scale service provision, so long as the charging structures are appropriate. Innovation is also a key imperative, and it can be a challenge to deliver business-as-usual services while ensuring new approaches are championed. CSSs can help by firstly taking away some of the burden of the day-to-day and freeing up local commissioners to innovate, and secondly by acting as a source of some innovations in their own right, translating successful initiatives from other settings. We believe that expert commissioning support will be delivered through alliances and partnerships that embrace many different types of organisations. Experts will need to be sourced from the very best that the public, private, academia and voluntary sectors can offer.

5. What partnerships or planned partnerships do you have?
We are interested in partnerships which can clearly demonstrate that they add value to our brand promise. We instinctively know that a partnership of public, private and academia can be a force for good and we can evidence that.

We are particularly proud of our on-going partnership with the NHS (CSUs and CCGs) and we have established a tremendously rewarding collaboration with Johns Hopkins University in Baltimore, USA. We have developed a rich network of suppliers that encompass the world of software development, advisory and change management.

Biography

How does your career so far help you in working with the NHS?
Before founding Sollis in 1994, I spent ten years working in the NHS. I started as a NHS management trainee back in 1984 and over ten years I worked at a variety of organisations.
Sollis work exclusively with the NHS. Since 1994 we have created and implemented a range of software solutions that deliver information from data. We now call this commissioning intelligence. Sollis were in at the beginning of healthcare commissioning and over the twenty years of our existence we have seen a lot of change. It has been a long and interesting journey and I have therefore learnt a lot about commissioning. I think I've earned some campaign medals along the way.

What attracted you to working in this area?
My mission is to be part of a company that makes things better; to make things better for the patients and citizens the NHS exists to serve. It really is as simple as that. Commissioning has had a chequered history, yet instinctively I believe it has an increasingly important role to play in shaping a future healthcare service that is affordable and relevant.
It is tremendously rewarding to see how intelligence generated from our innovations can make a real impact 'on the ground' to the lives of patients. I have seen this in action and it gives a purpose to our existence as a company. It is this which gets me out of bed in the morning.

What do you enjoy doing outside of work?
I am a cricket and football fanatic, with a passion for Newcastle United and Surrey CCC. I manage and captain an occasional - and utterly hopeless - casual cricket team. My two young children occupy whatever spare time is left!

6. What are the major challenges of working as a provider of CSSs?
Even after twenty years, visibility and awareness within the market presents challenges. This is largely a factor of the NHS's enduring love affair with re-structuring and re-organisation. The procurement cycle can be challenging. In spite of the Cabinet Office's stated aim of making government business more accessible to SME's the reality rarely matches the rhetoric.

7. How do you see the CSS market evolving?
Framework tenders can be notoriously difficult to navigate and the costs involved can prove daunting and often prohibitive. As a supplier there is of course a requirement for us to clearly articulate our offering and value proposition to the market. But this is a two way street and commissioners must also clearly define their needs, wants and desires in respect of their support requirements. To date this has proved challenging. The CSS market is clearly evolving and we crave the existence of a vibrant and diverse market in which SMEs can genuinely compete. 'Build it, and we will come'.

8. Do you have plans to enter into partnership arrangements with potential Lead Providers of CSSs?
Undisclosed.

TMI Systems

Commissioning support services

Director: Chris Wright

1. What CSSs will you provide over the next 12 months?
We provide cloud services including:
> Project and programme management.
> Shared service programme management.
> CCG collaboration using a cloud service to exchange project information, business cases and lessons learned.
> An integrated programme and performance management solution.

We also offer well as additional services to commissioning support units (CSUs) which support pipeline management and collaboration with other CSUs and business partners.

2. How is your business structured? How does CSSs fit into this?
Our client base is almost entirely UK public sector based and we've spent the past 12 months developing the Verto service to support the commissioning agenda. Our development teams have been working closely with clinical commissioning groups (CCGs) and more recently CSUs to ensure the Verto service meets their requirements.

3. What is different about your organisation, and why should commissioning organisations come to you?
We offer a proven service which can significantly improve commissioning outcomes. Our organisation is entirely public sector focused and we've worked closely with our clients over the past five years to develop a low cost, easy to use cloud service which supports their business needs and activities.

We can support both CCGs and CSUs with a flexible service that helps them to deliver efficiency programmes, realise benefits and collaborate with other colleagues.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?
We believe the key challenges are:
> Programme and change management.
> Integrating health and social care.
> Collaboration and partnership working.

The CSSs could adopt a cloud-first approach to the use of IT services and advocate the greater use of SMEs to provide services. Using the G-Cloud framework could also be promoted. CSSs could also provide a platform for CCGs to share experiences of working with small and medium enterprises (SMEs), possibly through the new CCG supplier directory.

5. What partnerships or planned partnerships do you have?
We have just started to work with South West CSU to manage their projects and programmes and pipeline business. We are embedding a projects and programmes management (PPM) methodology called Align into our service as part of a programme to improve the maturity of their Portfolio, Programme and Project Management Maturity Model (P3M3).

This is an important part of their ability to win future business and potentially become part of the lead provider framework. At the same time we are working with a cluster of CCGs in Cheshire to embed the NHS PPM methodology and support shared projects with other CCGs. Work has also taken place to embed indicator sets and performance measures so that project outcomes can be aligned to performance targets. In effect, consolidating programme and performance management. The service will be promoted to other CCGs from February.

6. What are the major challenges of working as a provider of CSSs?
Because many of the organisations are new it's often difficult to identify those responsible for specific services within the organisation. Similarly, individuals may be reluctant to engage with potential suppliers while roles and responsibilities are not fully established.

The benefits of new services such as having Cloud Software as a Service are not fully understood. SMEs tend to be overlooked when organisations engage with large consulting organisations and other service providers.

7. How do you see the CSS market evolving?
The CSS market may well become dominated by large business process outsourcing organisations, as they effectively provide a one-stop shop for CCGs. The lead provider framework now covers such a broad range of services that only large service providers will be able to meet the requirements. Despite our best efforts, we fear [CCGs will] have little incentive or motivation to seek out SME and VSO service providers to sub-contract their work. Ironically, our Cloud PPM service is not available from these organisations who still use traditional spread sheet and email

Facts and figures

Number of dedicated staff in the healthcare team: Five
Current CCG, CSU and other NHS customers: South West CSU, East Cheshire CCG, South Cheshire CCG, Vale Royal CCG
Percentage of your income/work from NHS contracts: Around 10% but growing quickly
In percentage terms, approximate growth in 2013/14 healthcare revenue attributed to the latest NHS structural reforms: 80%
Service coverage/types of service provided: Cloud based service known as Verto. It enables CSUs and CCGs to manage all of their projects and programmes online, track performance and outcomes. CSUs can manage their pipeline and demonstrate value for money to CCGs through real-time reports, time-sheets and highlight reports
Main competitors: SharePoint and other file storage systems. Microsoft Project Server and some performance management systems although none provide the workflow that Verto does

approaches. Unless SME engagement is mandated we do not believe the position will change.

8. Do you have plans to enter into partnership arrangements with potential lead providers of CSSs?
We have partnered with the South West CSU, part of the recently formed Ellis group. It is hoped our work there will be extended to other member CSUs and become part of the transformation service offered to CCGs. If they or a group of CSUs are successful in winning lead provider accreditation it could create a business opportunity for us. We will also actively pursue likely lead provider organisations later this year when our CSU work becomes established, in order to have our services included in their portfolio of services.

Biography

How does your career so far help you in working with the NHS?
In the earlier part of my career I worked in large organisations and held a number of executive level roles. I managed some large change management programmes and understand the challenges of transformational change in large organisations. Since 2000 I founded 3 software to provide cloud-based services for businesses. Since 2002 I have dealt almost exclusively with public sector organisations including local authorities and health organisations in the UK.

What attracted you to working in this area?
I often ask myself the same question as it can be a frustrating area to work in at times. Despite this, I believe the sector can provide exciting business opportunities to SMEs who are prepared to engage for the long term and adapt their services to meet the specific needs of their clients. If you are prepared to work hard and listen to your customers you can provide real value-added services which can then be replicated and provided in a cost effective way to other organisations. Unlike the private sector, once a reference site has been established a public sector client will often act as a reference to similar organisations and promote the use of the service and the supplier's work.

What do you enjoy doing outside of work?
Travel, meeting friends, eating out, watching football. Keeping fit, running, five a side. football and skiing.

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