Delivering the Forward View: the CCG Improvement and Assessment Framework

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NHS England is consulting on changes to the assurance framework for clinical commissioning groups (CCGs). This is the mechanism that helps ensure that the NHS locally is being run effectively by those organisations responsible for overseeing it (CCGs). The new process, the CCG improvement and assessment framework, aims to drive better NHS services in line with the *Five year forward view*, a major strategy document published by NHS England at the end of 2014.

Key points and recommendations

- The improvement and assessment framework will have a vital role in maintaining quality and promoting change in a period of significant financial constraint for the NHS.
- The ongoing crisis in the under-funding of social care will significantly undermine the ability of the NHS to meet many of the objectives outlined in the framework.
- CCGs must have a clear and explicit requirement to not only avoid discrimination but also to advance equality and protect individual rights in line with the Equality and Human Rights Acts.
- The indicator for NHS continuing care must not be included under “Sustainability” but rather “Better care”.

1. Introduction

Age UK welcomes the opportunity to feed into the proposed improvement and assessment framework for clinical commissioning groups (CCGs). This comes at a crucial time for the NHS. Taking place during a time of severe financial constraint, it is vital that local NHS services maintain high standards of care while also working to reform and change to better meet the needs of an older and ageing population. With more of us living longer, increasingly with complex needs, making sure the NHS is working effectively for older people is not only crucial to the wellbeing of a large proportion of our society but also crucial to the future of the health service.

Alongside this response, Age UK supports the comments submitted collectively with the Richmond Group of Charities, of which Age UK is a member. We particularly share the concerns expressed about the broader lack of meaningful involvement with patients and the public in developing this framework.

2. Social care

We appreciate the current funding crisis in social care is not within the scope of this consultation. However, we do not believe a functional NHS is possible without a functional system for social care. Our report *The health and care of older people in England 2015*[1] showed the huge reduction in spending on social care, which has accelerated since 2010. This pattern of reduction has led to severe restrictions on eligibility with access to support at “moderate” needs virtually disappearing and even “substantial” needs being increasingly squeezed out.

[1] Available here: http://www.ageuk.org.uk/professional-resources-home/research/reports/care-and-support/the-health-and-care-of-older-people-in-england-2015/

With local authority social care departments experiencing deep cuts, this not only increases the chances of people needing more, avoidable, acute healthcare, but also limits the ability of hospitals to discharge people home in a timely manner. We welcome reference to the latter issue in the proposed indicators, but we strongly reiterate the need for urgent action on resolving the crisis in social care being experienced by older people.

3. Equality and human rights

We are concerned that the current framework does not reference duties under the Equality Act 2010, including the public sector equality duty. CCGs are necessarily subject to all duties in the act, but we believe these need to be explicitly stated in the framework and be included in the metrics under the requirements for being "Well-led". In light of a drive to deliver more services in cost-efficient ways, it is vital that there is neither conscious nor unconscious discrimination in the delivery of services.

There is wide evidence of discrimination with regards to older people's access to care in areas including cancer, mental health and surgery. In periods of low spending growth in the NHS, older people's access to procedures such as hip and knee replacement and cataract surgery as well as eligibility for equipment such as hearing aids has been slowed or restricted. The recently published Mental Health Taskforce report highlighted inequalities in the care of older people as a specific issue and is clear in its recommendations that improvements must be both relevant to all ages as well as targeted at groups currently experiencing known inequalities.

CCGs must have a clear and explicit requirement to not only avoid discrimination but also to advance equality. We would also expect recognition of their responsibilities under the Human Rights Act, ensuring that in delivering their statutory functions, they do not oversee NHS services that would compromise the essential rights of individuals, whether in planning or delivery.

4. Proposed indicators

We propose changes to the following indicators:

5d. People with a long-term condition feeling supported to manage their condition

Older people are the majority users of health services and a large proportion of older people live with multiple long-term conditions. For people over 75, the majority will live with more than one and many with 3 to 4. We would recommend reflecting NHS Outcomes Framework indicator 2.7 *Health-related quality of life for people with three or more long-term conditions* by amending this indicator as follows: *People with **single or multiple** long-term condition**s** feeling supported to manage their condition**/s***.

6. Inequality in avoidable emergency admissions

We believe this indicator risks putting pressure on local areas to reduce levels of emergency admissions in places where there is likely to be higher levels of overall morbidity. For example, older people living in the most deprived areas will live longer at the end of their lives with disability compared to people in the least deprived areas. It is reasonable to expect demand for services in areas with higher levels of disability will be greater. The drive to reduce health inequalities and variation in avoidable emergency admissions is vital, but we do not believe this is the mechanism with which to assess

progress. It risks reducing access to essential services and may do little to address the underlying causes of this inequality such as the broader impact of poverty and the lower relative provision of primary care services. The terminology is also unhelpful in the light of points made under section 3 above. We would recommend rephrasing this indicator to *Variation in avoidable emergency admissions*.

10d. Implementation of Mental Health crisis care and liaison psychiatry services

The Mental Health Taskforce report, recognising the significant benefits to older people's wellbeing, historic under-provision, and opportunity to support faster discharge, recommended that "older-age acute physical health services have access to liaison mental health teams – including expertise in the psychiatry of older adults". This recommendation should be reflected in either the body of this indicator or in subsequent guidance.

20. People eligible for standard NHS Continuing Healthcare

We strongly object to this indicator being included under "Sustainability". There is a very clear implication in the combination of the wording of this indicator and the area in which it sits that CCGs should be proactively reducing the numbers of people eligible for CHC. People must be able to expect packages of care that reflect their health needs and where it relates to a primary health need, this should be paid for by the NHS. It is only reasonable to measure success through lower utilisation of CHC where this need is prevented through better proactive care or through better planning, particularly through a hospital stay, Furthermore, the National Framework is explicit in saying: "Financial issues should not be considered as part of the decision on an individual's eligibility for NHS continuing healthcare". Therefore, this indicator should feature under "Better Care". NHS England should also consider measuring average waiting times for decisions on eligibility as a basic indicator of how well CHC is being managed by CCGs.

22a. Plan in place for delivery of digital services

We support the drive for a more digitally connected NHS and understand the necessary groundwork required in the background IT infrastructure. For anything patient-facing, CCGs must account for older people as a group most likely to be digitally excluded. Two-thirds of people aged 75 and over and three out of ten aged 65 to 74 do not use the internet. Roll-out of "digital-only" approaches must make sure services are still accessible to older people, particularly as the group most likely to be: accessing services; getting regular prescriptions; and likely to benefit from joined-up approaches to care.