In collaboration: PCC and NHS Networks

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Commissioning EXCELLENCE

Money worries and support top CCG concerns

More than one-third of clinical commissioning groups are worried about their organisation's prospects of balancing the books, a survey suggests.

Some 36% of the 47 CCGs who responded to the survey said they were "extremely concerned" or "very concerned" about the challenge facing their organisation in achieving financial balance. That figure soars to more than 80% if those voicing "moderate concern" are included.

The survey was conducted by Primary Care Commissioning (PCC) and Capsticks, a leading healthcare law firm. It attracted responses from almost a quarter of the 211 CCGs with responses coming from a range of CCG officials – most of whom were board members.

Several took the opportunity to provide additional comments with one saying "we have no money" and a second saying that the financial challenges for this year "are nothing compared with the long-term challenge".

Another commented: "The £25 management resource limit is crippling and dangerous."

CCGs are also anxious about the prospects of working effectively with commissioning support services and NHS England's area teams.

Just over two-thirds admitted they were "moderately", "very" or "extremely concerned" about relationships with the organisations charged with supporting and overseeing them. Almost two-thirds expressed similar levels of concern about working with member practices and secondary care.

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Better data key to financial balance and improved care

Data quality could determine whether or not clinical commissioning groups (CCGs) achieve financial balance, according to a provider of a system for checking hospital payments.

The iQV Budget and Data Manager data validation system enables CCGs to verify bills for secondary care treatment to eliminate coding errors and charges for treatment that never took place, allowing individual CCGs to save tens of millions of pounds. The money could help CCGs to avoid overspending commissioning budgets or fund further treatment for patients.

With nearly half of CCGs authorised with financial conditions and financial balance and QIPP objectives emerging as top concerns in a recent survey (see story, left), data quality is emerging as a top priority.

Andrew Wood, chief financial officer, Fareham and Gosport and SE Hampshire CCGs, said: "A priority for every finance officer is to review the way that SUS bills are validated, as historically the data, according to the Audit Commission, contains substantial errors. With financial balance being a key element of CCG authorisation, it is important this objective is achieved particularly in the first year."

The problem of inaccurate hospital payment data was highlighted last year in a report by the Audit Commission, which put the cost of errors at £2.25 billion.

Existing data validation systems AIV and SLAM identify only around 45% of errors in secondary uses services (SUS) payments. iQ Medical claims its system more than doubles the error detection rate to 95%.

Using real data from a CCG in the east midlands, iQ Medical identified 9.5% of the SUS bills from one hospital trust were presented without evidence that the treatment had taken place. The potential saving to the CCG, which has a £156m secondary care bill, could be £25.7m if the trusts fail to deliver the required evidence – enough to fund thousands of outpatient appointments and surgical procedures. AIV and SLAM alone identified only £6.6m of payment errors.

Graham Poulter, managing director of iQ Medical, says this is not an isolated case. "The Audit Commission identified poor data validation as an NHS-wide issue and PCTs lacked the will to do anything about it. They simply paid the money over to the hospital trust and in the handful of cases where they attempted to claw anything back it usually took the form of a deal worked out with the hospital finance director on the golf course."

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GRAHAM POULTER

Better data key to financial balance

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CCGs are unlikely to be so casual. With 101 of the 211 CCGs granted authorisation with financial strings attached and CCG QIPP plans likely to be scrutinised closely by NHS England, finance directors will be keen to plug any leaks in hospital spending.

"Where PCTs tended only to question secondary care bills after they had already been paid, we expect CCGs to withhold payment until they see the evidence. Under the NHS standard contract they can retain 1% of the total value of secondary care payments if the trust fails to come up with the evidence in time and the figure could be very much higher if the evidence is never forthcoming."

"Until now trusts have had no reason to worry about poor data, but if CCGs exercise their rights to withhold payments the hospital will get its act together."

iQ Medical says it is at "an advanced stage in discussions with ten CCGs", several of which are ready to embark on trials with all or some of their GP practices. The iQV system depends on the co-operation of local practices which need to improve the clerical procedures in which payment requests from secondary care providers are matched to episodes of care recorded in GP clinical systems. "Variations across practices have compounded the incompetence of hospital finance departments, but the clinical incentive for getting it right is that practices and their patients will benefit from releasing funding that would otherwise have been swelling the coffers of the local hospital trust."

Poulter acknowledges that any big savings for CCGs are likely to be one-offs, but warns that they must be monitored continuously if the problem is not to recur. "Until now trusts have had no reason to worry about poor data, but if CCGs exercise their rights to withhold payments the hospital will get its act together. That will reduce the chance that CCGs have to pay for errors in future, but it will also mean that the data available to commissioners for planning purposes will be of higher quality, increasing the prospects of putting the right services in place for patients."

- Support CCG to reach financial balance by avoiding needless overspends
- Produce two to four times retained saving compared to existing systems
- Release savings to be reinvested in care for patients
- Enable CCG to meet QIPP objectives
- Improve CCG budgeting
- Provide stronger evidence for future contract negotiations
- Promote more efficient financial processes in secondary care
- Improve quality of data used to inform clinical and commissioning decisions

Figures in detail: http://bit.ly/18rLF5c
iQ Medical: http://www.iq-medical.co.uk/

Newcastle MSK pathway goes back to the future

Three consultants working in the community helped convince GPs in Newcastle to support implementation of a seven year old Department of Health framework for redesigning musculoskeletal services.

West Newcastle Clinical Commissioning Group (CCG) worked with Connect Physical Health, Newcastle upon Tyne NHS Foundation Trust and local GPs to redesign the MSK pathway.

The redesigned pathway was introduced between 2010 and 2012. It includes:

- All physiotherapy referrals coordinated via a call referral management centre
- Physiotherapy delivered at GP practices – reducing waiting times and hospital visits
- A one-to-one expert physiotherapy telephone assessment and advice consultation service, enabling access to immediate information for patients and support from their own homes
- Orthopaedic and sports and exercise medicine (SEM) consultants are part of the clinical assessment team, enabling patients to access specialist help in the community.

A two year pilot showed that episodes of care increased by 62% while reducing overall expenditure.

SEM consultant and Connect Physical Health's clinical lead, Dr Graeme Wilkes, says the 2006 framework provides an excellent basis for redesigning MSK services.

"I got several copies of the document to take around GP leads and raise awareness. It seemed a very good model and I can see that we have pretty much followed what it said. The difficulty in the past has been persuading GPs and commissioners to address the task of modernising the pathway because there have been so many different things going on."

The service ensures that patients have much faster access to physiotherapy – which can prevent deterioration which ultimately makes treatment more expensive. Those patients requiring surgery get faster access to orthopaedic surgeons.

However Wilkes says that persuading GPs that the new pathway was good for patients and commissioning budgets remained a challenge.

"We do need a change in GP referral behaviour. GPs have a responsibility to consider whether their referral is best for both the patient care and for NHS finances. We think the pilot pathway/ MSK framework of 2006 provide reasons to modernise and to move away from referral direct to secondary care."

Fears CCG quality assurance could become tick-box exercise

NHS England's interim framework for quality assuring clinical commissioning groups (CCGs) could become an overly-bureaucratic box-ticking exercise, commissioners have warned.

The interim framework, which was published in May and is now the subject of consultation, proposes 18 measures under three "core elements": delivery, capability and support needs.

However the document received a cool response from NHS Clinical Commissioners (NHSCC).

Dr Steve Kell, co-chair of NHSCC's leadership group and chair of Bassetlaw CCG said: "NHSCC has some reservations about the current form of the CCG assurance framework.

"We are concerned that it is not clear where the assumed liberty fits and that quarterly performance reviews are potentially excessive and time-consuming. There is a real risk that the implementation of the assurance framework will become an overly bureaucratic box-ticking exercise.

"It is important that the final document provides assurance that CCGs are delivering the outcomes expected of them for their public and patients. But it must do this in a way that measures what matters, is proportionate and recognises the complex inter-dependencies across the commissioning system."

Acknowledging the need to monitor CCGs' progress, Kell said: "Assurance and review is important but it needs to be aligned across the system. We need to see the specialist commissioning assurance framework and assurance processes for public health commissioning alongside and aligned so that we can assess outcomes across organisational boundaries."

NHS England emphasised that assurance would be agreed with not imposed on CCGs and that the current document was a work in progress. In a statement introducing the assurance framework, it said: "The publication of the interim assurance framework kicks off an engagement process with CCG staff, patient groups and other key stakeholders which will inform a final framework to be published in the autumn."

The document is available at http://tinyurl.com/pq759vp

"Assurance and review is important but it needs to be aligned across the system so we can assess outcomes across organisational boundaries."

Lancs plans to adopt Staffs engagement model

Clinical commissioning groups (CCGs) in Lancashire are set to benefit from an award-winning model of patient engagement developed in Staffordshire.

The "model of insight" consolidates reactive feedback such as complaints with the findings of public and patient involvement work to produce a patient experience dashboard. In Staffordshire, where it was initially developed by the former North Staffordshire Primary Care Trust, all six CCGs have adopted the model – with four of them establishing 'patient congresses' to give patient engagement a more strategic role.

Commissioning Excellence reported in November about the Staffordshire team's success at a national health IT award. Three CCGs from outside the county have agreed to adopt what is effectively a retail-style customer relationship management approach to public and patient involvement.

With Staffordshire and Lancashire commissioning support units now under one management structure and working as one entity, development work is underway to provide this model of engagement to the eight Lancashire CCGs.

David Rogers, senior executive for communications and engagement (Lancashire) with Staffordshire and Lancashire Commissioning Support Unit, said: "This is a very impressive approach to understanding and using patient experience. Post-Francis, CCGs are seeking hard and soft data concerning patient experience. The patient experience dashboard provides real time intelligence about patient experience and it will provide our CCGs with valuable insight and knowledge from which to inform clinical commissioning.

"CCGs are very focussed on the needs of patients and while GP member practices have good local knowledge and strong relationships with their patients, the key is being able to spot trends and patterns at practice, locality and CCG level before those trends become critical issues. The patient experience dashboard provides this and I will be working to provide this to Lancashire CCGs to give them this vital intelligence and assurance."

Lesley Goodburn, head of communications and engagement with the Staffordshire arm of the CSU and the driving force in developing the model three years ago, described the impact of patient congresses where they had been adopted.

The congresses involve around 20 patients or members of voluntary groups and their monthly or bi-monthly meetings are chaired by the CCG PPI board member.

"It is still early days and so far the biggest change has not necessarily been around service redesign because we have been through a period of transition. What they have done is embed PPI in CCGs and ensure it is not an afterthought. Congress members are told about major commissioning or re-commissioning proposals at an early stage so they are involved at a strategic level with members part of the project group studying those proposals."

Lesley Goodburn is one of the speakers at the 3 September event CCG Summit: Building Public Support for Change.

For information about the event: www.pccevents.co.uk/pppsummit

DIARY DATES

Transforming services for improved outcomes 16 July, London

Commissioners can't deliver transformational change on their own. They need to work with a broad range of support services and providers. With a keynote from Bob Ricketts, who leads NHS England's drive for choice and quality of commissioning support services, this event also features case studies and expert sessions on planning for effective outcomes. Other sessions include a CCG-led workshop on transforming urgent care and insights from provider group GP Care. Plus legal advice on how to use the levers in the NHS standard contract and get to grips with the procurement rules.

http://bit.ly/18NK0qU

CCG summit: building public support for change 3 September, London

Engagement should be part of everyone's job description and woven into the fabric of commissioning not treated as a low-priority business process. But with CCGs struggling with urgent financial problems and crises of care, getting patients and the public involved in commissioning may seem like a luxury. This event illustrates how good engagement underpins CCG ambitions to change services and how without it CCGs will not have the evidence on which to base commissioning plans or the support of local populations to enact them. With speakers from NHS England, Healthwatch and patient groups as well as leading practitioners.

http://bit.ly/17TDlMm

BETTER NHS NETWORKS hub now connects 75,000 people

The NHS Networks news and virtual networking hub has a new look and now serves a community of 75,000 across the NHS.

The service, which is free to use and funded by PCC, is adding new users at the rate of around 100 a day. The weekly newsletter has a readership of more than 40,000.

The redesign unveiled in May is intended to make the site more attractive and easier to use, according to development director Julian Patterson.

"Some features, such as event listings and the connections function, which allows individuals to link directly to other users much as they can on LinkedIn, were not very obvious. Usability research told us that people were struggling to work out how to use parts of the site. We addressed these issues and made it clearer on the homepage exactly what the service is for."

Patterson says the rapid rise in user numbers is only partly explained by the revamp. "The changes in the NHS, particularly the closure of PCTs and the creation of CCGs, CSU and NHS England area teams have moved a lot of people around. Individuals and organisations have a greater need than ever to stay connected," he says.

"We've seen a lot of interest from CCGs, which have to engage with a wide community beyond their immediate organisations. Even if you have your own website and intranet, you can't include everyone you need to work with now or may need to connect with in future. NHS Networks bridges the remaining gaps."

Anyone can sign up for news alerts and the weekly newsletter or post in forums. NHS-related organisations and communities of interest can also set up open or invitation-only private networks to share news and documents and run discussion forums of their own.

NHS Networks offers advice and support for groups interested in running networks and getting the most out of the service.

Contact maria.axford@networks.nhs.uk for details.
www.networks.nhs.uk

MONEY WORRIES AND SUPPORT TOP CCG CONCERNS

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The survey also suggests unease about the leadership and capability within CCGs themselves. A quarter of participants said they were "extremely concerned" at the quality/experience of their own organisation's leadership, with others saying they were "very concerned" or "moderately concerned". More than six in ten expressed at least moderate concern at the capability of their CCG's leadership team.

Just over 80% of respondents were at least moderately worried about making major service changes and building public support. Tackling unwarranted variations in primary care is causing a similar level of angst for 72% of CCGs.

Julian Patterson, director of marketing and communications at PCC, said: "The weight of responsibility and expectation on CCGs is enormous and there are naturally some anxieties particularly in the area of financial viability. But in a system often criticised for complacency and lack of self-awareness, it is encouraging to see the frankness of many of the responses and the desire of CCGs to get to grips with the uncertainties they face. It's the ones that aren't worried that you probably need to worry about."

James Reynolds, head of primary care at Capsticks, said: "What this survey demonstrates is that CCG leads are under no illusion as to the scale of the challenge but there is light at the end of the tunnel. What is clear is the recognition that relationships will be crucial to how CCGs develop and it is encouraging that the majority of CCG leads are positive about forging effective relationships with, among others, local authorities, public health leads and health and wellbeing boards."

NHS England business plan sets the bar high


CHRIS MAHONY

The influence of the Mid Staffs scandal and ensuring independent inquiry runs through NHS England's first formal business plan.

The business plan includes an 11 point scorecard with the top two priorities being "satisfied patients" as measured through the friends and family test and "motivated and positive NHS staff", as measured by the equivalent test for staff.

Results for both tests are expected to be updated and published monthly. While it is not clear whether CCGs and providers will be expected to produce monthly reports, the prospect of regular reporting may not be universally welcomed by organisations already buckling under the weight of bureaucracy.

A spokeswoman for NHS England said: "As part of development of the friends and family test, we have tried to keep the impact on providers as low as possible, while still collecting valuable information that promotes improvement in quality.

"As we work on developing the friends and family test for use across all NHS funded services, we will review what impact additional collections may have on the NHS."

The business plan says: "Our touchstone of success above all others will be if patients would recommend their local NHS care and if individual NHS staff members have faith in the service they are contributing toward. We know there is good academic evidence of a relationship between patient experience of care and staff feeling supported and valued in their work. It is these indicators that will tell us if all others are amounting to genuine quality where it matters."

The business plan also makes clear that clinical commissioning groups (CCGs) will be held to account and expected to deliver on their improvement plans. The board pledges to "continue to publish an outcome indicator set for CCGs that demonstrate to CCGs and the populations they serve the quality of the health services they commission and associated health outcomes".

CCGs will be expected to deliver by next April some 80% of the outcome improvements they identified in their plans.

PCC development manager Sally Simmonds said the business plan set out a surprisingly ambitious plan for CCGs in their first year.

"If NHS England has set their strategy in stone they must have consulted widely to ensure the people it affects can deliver. It would be interesting to know how much discussion had taken place with CCGs about outcome targets and how much of it took place before plans had been published. The 80% target may or may not be tough. It depends on the ambition of the individual CCG."

NHS England defended the expectation on CCGs to deliver significant improvement by next year.

The spokeswoman said: "We recognise that some CCGs may find this challenging but, at the same time, we know they are ambitious for the communities they serve. Our area teams are in continuous dialogue with CCGs and partners on health and wellbeing boards about the level of ambition they want to achieve in terms of local health improvement."

Highlights of the plan

- Quality premiums for 2014/15 are linked to the strong focus on mental health. Commissioners and providers, particularly in primary care, are expected to raise their game
- CCGs are expected to enable a better integrated commissioning system encompassing local authorities, other local commissioners and providers. This objective will be central to the "assessment and in-year monitoring of CCG commissioning plans" and represents a big challenge
- The NHS Commissioning Assembly and its working groups provide a national forum for CCGs and NHS England teams, a point mentioned by the business plan. The assembly was part of the organisational diagram of the reforms, not a product of the CCGs themselves, fuelling the continuing suspicion that CCG "freedoms" are still being carefully managed
- Plans to improve choice for patients include the publication of quality and outcomes data covering consultants in ten specialist areas to inform commissioning and referrals. The timescale for publication is ambitious – this summer, according to the business plan
- Despite the departure from NHS England of the some of the main architects of QIPP (Jim Easton and by March 2014 Sir David Nicholson), the business plan makes clear there will be no easing off the efficiency drive. It does suggest, however, that CCGs will be left to make their QIPP plans with little interference or formal scrutiny by NHS England. With area teams themselves under pressure to achieve QIPP, it is difficult to see how NHS England can avoid imposing performance measures on CCGs – a point covered somewhat obliquely in a passage where CCGs and area teams are encouraged to "align" and "integrate" their QIPP plans.

http://tinyurl.com/clssgfn

KING'S FUND: work with providers to fix urgent care

Emergency and urgent care commissioners should shift from an "overly adversarial approach" to one that focuses more on outcomes and challenging providers, according to a King's Fund review.

The review, which was commissioned by the former NHS South of England in response to rising demand for urgent and emergency care services, voiced concern that commissioners sometimes lack a strategic approach to emergency care and a clear view of the overall system and its capacity. It said that successes in improving emergency care appear to have been driven by providers – sometimes despite, rather than because of, commissioners.

It concluded: "The key message here is that the model of commissioning emergency care needs to be rethought with providers given a stronger leadership and responsibility in determining delivery. Commissioning emergency services needs to shift from a sometimes adversarial approach of micro-managing performance to one where CCGs take an oversight and scrutiny role, supported by a system dashboard that highlights capacity and demand."

The review also recommended that commissioners:

- Develop a clear understanding of the flows through their system
- Focus less on specific disease pathways and more on sub-groups with a high level of need (such as those with multiple comorbidities or older people with mental health problems); on variations (such as the ratio of GPs per thousand population) and risk factors (such as shortages of key medical staff and access to diagnostics).

The review suggested that frequent reorganisation of commissioning organisations has exacerbated the challenges involved in tackling the rise in A&E attendance and emergency admissions.

Confusion and the loss of experience and knowledge as people move posts "seems to be behind some serious weaknesses in the whole cycle of commissioning", the King's Fund team warned. It did however find widespread support for GP commissioning, reporting that hospital trusts found CCGs to be enthusiastic and willing to listen and to work in partnership.

Read all about it: new prescription for depression

Feel the Fear and Do it Anyway is the best-known of the 30 titles on the first "books on prescription" programme to help people with depression and anxiety.

The Reading Agency and the Society of Chief Librarians have compiled the list with the support of a plethora of royal colleges and other healthcare organisations – and the Department of Health. The list is based on guidelines issued by the National Institute for Health and Care Excellence and the books will be available from local libraries in England to help people understand and manage their condition.

The books will provide text-based cognitive behavioural therapy (CBT) to help people with common conditions like phobias and some eating disorders, as well as depression and anxiety. The new national scheme builds on similar local exercises that started in 2005.

Paul Blenkiron, a consultant in adult psychiatry who was involved in drawing up the list, said: "This project will bring help to the millions of people who suffer from anxiety and depression. I am sure GPs and other health professionals will value the Reading Well Books on Prescription scheme. CBT can be a highly effective treatment for people with common mental health problems. The core list of 30 CBT-based self-help books will be a real boost to the treatments currently available."

The books will be available free on loan as usual from many libraries.

The full list will be available from the Reading Agency website when the scheme is launched this June.

http://readingagency.org.uk/

INSURANCE POLICY for media mishaps

CCGs face communications risks which must be managed at the policy level, and not simply by investing in CSU support.

For example:

- After a meeting-in-public, a journalist takes the CCG chair to one side and asks a series of benign-sounding questions. The chair answers in good faith, but the next day's headline is "GP commissioners will not fund life-saving drug". Other CCG members are furious, and a storm of letters follows in the local paper. Then a national tabloid rings…
- After attending a social media seminar, the chief operating officer delegates his PA to tweet and Facebook. One month later the PA is staring at a disciplinary panel, after a poorly worded update was retweeted across the web…
- The CCG receives an unexpected payment demand for £8,000 from the Newspaper Licensing Agency. Apparently members of staff have been photocopying newspaper articles without permission. No one ever told them not to…

A good commissioning support unit can do a lot to limit the damage of these not-if-but-when reputation problems. But the CCG can do the lion's share to prevent them by adopting robust communications policies. As well as clarifying what everyone can, cannot and should do, policies protect the organisation from the proverbial maverick member, and give confidence to staff to do their jobs.

The downside? Developing a set of communications policies requires considerable expertise and experience. There are, of course, many consultants who will be happy to charge you for several days work to do it, but in these times of austerity this may seem like too much of a disbursement… until something goes wrong.

PCC is working on the answer, at a fraction of the cost…

Details of the new product will appear in the next Commissioning Excellence.

For more information contact karen.topping@pcc.nhs.uk

LOCAL AUTHORITY BRIEFING

Getting to grips with pharmaceutical needs assessments

Directors of public health believe they have two years before they start to worry about pharmaceutical needs assessments (PNAs). Yes and no. While it is true that they won't need to produce their first PNA until 2015, local authorities should be aware of the duty to review the PNA they inherited with the transfer of public health responsibility from the NHS to make sure it is fit for purpose. They should also be aware of the time it takes to conduct a PNA – at least 12 months according to this briefing from PCC, which outlines the role of the PNA and explains why local authorities cannot afford to be complacent.

http://bit.ly/YsODTK

Local authorities handed responsibility for key NHS screening programme

Local authorities are now responsible for commissioning NHS health checks, a national prevention programme provided locally – currently largely by GPs. This briefing provides information about the programme, which screens people between 40 and 74 for signs they are at risk of heart disease or stroke. The document outlines why health checks are important, what a check consists of, their cost-effectiveness and the factors local authorities should take into account when commissioning them as part of their new public health responsibilities.

http://bit.ly/ZutdF2

Responsibility for pharmacy 'enhanced services'

Responsibility for public health enhanced services provided by pharmacies transferred in April from former primary care trusts to local authorities. These include needle and syringe exchange, chlamydia and other screening services, smoking cessation and emergency hormonal contraception.

Where such services are commissioned by local authorities they no longer fall within the definition of "enhanced services" or "pharmaceutical services" as set out in legislation and therefore should not be referred to as enhanced services. However, local authorities can ask NHS England to commission such services from pharmacy contractors.

http://bit.ly/Zutloa

JULIAN PATTERSON

Complacency is the least of your problems

Our survey of CCGs in April may not present the most optimistic picture compared with the many recent polls of this group, but its saving grace is the absence of bravado. There is also no sign of the complacency that infuriated critics of PCTs.

But the fact remains that CCGs have a lot to worry about, with financial balance and the demands of the QIPP programme at the top of the list but a heap of concerns close behind including quality of leadership, capability of staff, relationships with other organisations, commissioning support and – inevitably, given the timing of the survey – the state of their own organisations.

"We are a shambles," was the painfully frank assessment of one respondent. A GP member of a CCG board said: "We just don't understand the issues. We trained as doctors to treat patients not to manage the biggest organisation in the country. I am thinking of retraining as a brain surgeon as I am sure it will be easier than this."

However confident they become in their own abilities, the success of CCGs will depend on their ability to manage multiple relationships, co-operate with other agencies to develop strategy and work through operational issues, and negotiate roles and responsibilities that have been left ill-defined. Assumed liberty or botched policy making? It's academic now.

CCGs will also need a range of practical support to provide the skills and expertise they lack the scale, resources and time to develop in-house.

Commissioning support units will play a crucial part but CCGs have doubts about the quality and range of services that will be provided.

As one respondent put it, "I am concerned about the ability of our commissioning support organisation to deliver [procurement and commissioning support] and their capacity for ambition in these areas. They don't seem to always 'get' the new world."

The signs are that CSUs will at least be in their comfort zone providing transactional services, so while CCGs remain pre-occupied by financial issues CSUs should be able to help. Bigger problems will emerge when CCGs go looking for softer skills such as the engagement expertise that they will need to build public support for change or the PR skills to manage the inevitable media crises.

NHS England and its area teams also need to support CCGs, but a host of issues remain to be worked out in the delicate and potentially fraught relationship with area teams. NHS England will manage primary care contracts but wants CCGs to manage primary care relationships – a difficult division of responsibilities the rules for which are unclear.

Making all of this work will require maturity and co-operation that needs to be switched on now but will take time to nurture.

CCGs will also need the support of their general practice members and wider primary care community, organisations with pressures and worries of their own. Actively or passively disengaged GPs - buckling under workload, anxious about income, fretting about out-of-hours services, angry about A&E and worried about what's going to happen to the people they see in their surgeries if they don't hold it all together - will not be easy to marshal into the clinically driven, harmonious co-operatives envisaged by the architects of reform.

Finally CCGs will need the support of the public, who perceive little of the altruism and optimism that motivated clinicians and managers to volunteer for leadership roles in the new system.

They see an NHS under attack or up for sale and CCGs, if they enter the public consciousness at all, will need to establish themselves quickly as local heroes or risk being branded as the hapless stooges of the reforms.

The final challenge to add to a long list is that however enthusiastic they may be, the new commissioning organisations are just that – new. No commercial start-up would be expected to deliver return on investment at the rate expected of CCGs. There will be months, perhaps years of bedding in systems, working through operational issues and forming the relationships on which success ultimately depends.

There needs to be time for reflection, learning and planning not just relentless pressure to deliver. CCGs will need to fight for this freedom in a system giddy with urgency. Otherwise there is a real prospect of failure.

So CCGs can be forgiven their concerns, congratulated for spotting the dangers that surround them and applauded for their composure in the circumstances. If any of them were spurred on by hubris, they're over it now.

Find out how we can support your CCG:
http://www.pcc-cic.org.uk/services

Commissioning Excellence is supported by PCC and NHS Networks. Contact julian.patterson@pcc.nhs.uk or visit www.pcc-cic.org.uk and www.networks.nhs.uk