1. Introduction

NHS Wakefield Clinical Commissioning Group (CCG) is committed to involving the public, patients and carers in all that we do. An essential part of this is engaging with people about our priorities and strategic plans. On this occasion we decided to do something different to the questionnaires and workshops we have undertaken previously. In June 2015 the CCG’s Executive Team and Clinical Cabinet agreed to develop an engagement tool called The Commissioning Maze created by the Vale of York CCG and Healthwatch North Yorkshire in partnership with Integral Design Ltd. This would be used as a mechanism to engage with the public and stakeholders about difficult decisions and inform our commissioning priorities for 2016/17.

2. Our engagement responsibilities

For NHS Wakefield CCG engaging people is not just about fulfilling a statutory duty or ticking boxes, it is about understanding and valuing the benefits of listening to patients and the public in the commissioning process.

By involving local people we want to give them a say in how services are planned, commissioned, delivered and reviewed. We recognise it is important who we involve through engagement activity. Individuals and groups play different roles and there needs to be engagement opportunities for both.

There are a number of requirements that must to be met when discussions are being made about the development of services, particularly if any of these will impact on the way these services can be accessed by patients. Such requirements include:

- The White Paper, ‘Equity and excellence: Liberating the NHS’
- Health and Social Care Act 2012
- The NHS Constitution

The White Paper, ‘Equity and excellence: Liberating the NHS’, and the subsequent Health and Social Care Act 2012, set out the Government’s long-term plans for the future of the NHS. It is built on the key principles of the NHS - a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. It sets out how the NHS will:

- put patients at the heart of everything it does, ‘no decision about me, without me’
• focus on improving those things that really matter to patients
• empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

It makes provision for CCGs to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners, and it also places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution - and to promote awareness of the NHS Constitution.

Specifically, CCGs must involve and consult patients and the public:

• in their planning of commissioning arrangements
• in the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
• in decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact

The Act also updates Section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

The duties to involve and consult were reinforced by the NHS Constitution which stated: ‘You have the right to be involved directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services’.

3. What was the purpose of the Commissioning Maze?

• To contribute to and inform the annual planning cycle and commissioning priorities.
• To help people to understand the financial climate and difficulties that face commissioners. Including the difficult decisions they have to make.
• To help staff to hear first-hand from the public, what their concerns are and what they value about services.
4. What we did

A steering group was formed that met on a regular basis to develop a set of questions that would be the basis of the game. This proved very challenging and colleagues are thanked for their perseverance to “get it right”.

Staff involvement in the development continued with the “Game” being piloted with certain groups:

- 15th July 2015 - Planning & Delivery Group
- 13th August – Informal Clinical Cabinet
- 25th August – Lunch & Learn
- 13th October – Executive Team

After further refinement, the development of 10 sets of the “Game” and a publicity campaign, it was rolled out to the public.

Events:

- 17th November 2015 – Unity Works, Wakefield 1
- 26th November 2015 – Kinsley & Fitzwilliam Community Centre
- 3rd December 2015 – Pontefract Town Hall
- 3rd February 2016 – Practice Reference Group Network members
- 23rd March 2016 – Ashgrove Surgery PRG
- 24th March 2016 – Newmillerdam

Through this process we engaged, debated and listened to 62 members of the public. At one of these events and via its development we engaged with 30 NHS and Local Authority staff and Governing Body members too.

5. What people said

In order that the information we have heard helps to develop our Sustainability and Transformation Plan responses have been framed into the intended priorities for that work.

- These are: The Gaps: Health & Wellbeing; finance & efficiency and; Care & Quality
- Wakefield Place priorities: Primary Care (variation); Integration and; Prevention
- Enablers: Workforce and; Digital

It should be recognised that not all groups answered all of the questions depending on how fast the “game” progressed.
Health & Wellbeing are all covered by the Wakefield Place Priorities:

a) Primary care

**Question:** Antibiotic resistance is one of the biggest threats facing us today; if we keep using antibiotics to treat conditions such as viral coughs, colds, and sore throats, they will eventually stop working against more serious infections. Spend £100,000 to fund primary care pharmacists who can review the prescribing of antibiotics in GP practices, and to include a public education campaign.

**Response:** People felt that GPs should be doing this anyway and that there was a good awareness that antibiotics should not be prescribed as much. There were decisions to either not fund or to fund from prescribing budget.

**Question:** A new inhaler is available which is identical to one that is prescribed a lot in Wakefield. The new one is 20% cheaper. Switch 50% of patients to the new inhaler and save £200,000.

**Response:** All people thought this was a “perfectly sensible” thing to do. Two groups asked why you would only switch 50%. However, some people thought patients should be given the opportunity to compare and highlighted how important communicating the change properly would be.

**Question:** The Prime Minister proposes to give £2m to successful bids from CCGs to improve access to primary care. Where would you spend this money? What would you improve?

**Response:** Groups did feel that access to GPs needed to improve. Ideas for spending the money were: more health trainers; more nurse practitioners; have mental health practitioners and improve nurse training. One group would like to see more Walk-in centres, more care for the elderly and preventative care.

**Question:** Feedback from patients surveyed about GP premises and rules on health and safety mean £1m of essential building repairs are needed to bring GP facilities up to standard. Local practices are unable to afford this expense so ask the CCG to provide the funds.
Response: Generally, people did not want the CCG to fund this work and felt that practices should find this money themselves. Two groups thought that practices should look at the buildings and assets in their community before spending on their own premises i.e., sharing. Groups asked how Primary Care services are currently funded and therefore thought that these could be self-funding once patients register.

“The GP is a business so they need to provide the estate management.”

Question: Should we have a consistent approach to extending primary care access across the district? If we did this, should £1.4m be reallocated from other aspects of GP services and the walk-in centre?

Response: Groups were concerned about GPs working longer hours but felt that it would prevent people going to the A&E. Two groups asked if money could be taken from the Walk-in Centre to have GPs in A&E as this would be more convenient for them. Patients also thought spend on nurses and triage was a good idea. Communications and publicity were essential to let people know where to go out of normal hours.

b) Integration

Question: In some areas of the country social prescribing has been shown to reduce demand on GP services and A & E attendances. It also improves quality of life and reduces loneliness and isolation. To set up social prescribing in our area would cost approx. £500,000 and has the potential to be cost neutral or cost saving in the long-term.

Response: People thought that investing in this was very important as it is important to build resilience in communities. They were very interested to know what the money would be used on. It was felt that once a referral system and infrastructure was set up it should not cost this much. They were keen for this to be evaluated but also wondered if it should be funded by Public Health.

Question: A survey shows that most people are strongly in favour of more voluntary sector investment to combat loneliness and isolation. This would cost £500,000.
There is no evidence of potential direct savings to the system, but loneliness linked to associated depression has a significant detrimental effect upon physical health as well as mental health.

**Response:** There was varying responses to this question. Although one group decided not to fund this initiative at all most did fund it but some were concerned about taking the money out of already stretched resource. Once again groups were keen for this to be evaluated. There was also a comment that this was better than the over-prescribing of anti-depressants.

**Question:** It is estimated that there are 35,000 carers in Wakefield. About a third of carers provide 20 or more hours of care a week. An investment of £600,000 would enable robust identification of important, unpaid carers, providing help and support to maintain them in their role and to prevent the negative impact on health.

**Response:** Groups were supportive of helping carers and thought it would cost a lot more than £600,000 if we had to pay for their help. However, they wanted to know exactly how the money would be funded and wanted to ensure this went to the carers not on bureaucracy and not just to identify carers.

**Question:** Most people near the end of life state a preference to die at home. Will you move £200,000 from the local hospice and use it to fund more community/voluntary sector support for people who wish to die at home?

**Response:** Groups were reluctant to take money from the hospice as they felt some patients wished to die there and carers were supported properly there. It was also acknowledged that hospices do care for people in their home. However, to give people choice one group thought the money could come from the hospital. One group took a vote 4 decided to take the money from the hospice and 2 people decided not to.

**Question:** In the Chancellor’s autumn statement, he announces that local authorities will receive further significant budget cuts. This is on top of large funding cuts over the past few years. In Wakefield this will affect Connecting Care, the joined up services provided by the NHS, social care and voluntary services in the community. It
could lead to a reduction in funding of £400,000 from this budget. Should the NHS pick up this responsibility?

**Response:** People felt that money for community services and public health should be ring-fenced. They wondered if it would be better to let the NHS oversee these services. However, it was acknowledged that this was essential work and not a large sum of money by some standards. All groups decided they would fund to secure services.

c) **Prevention**

**Question:** In Wakefield 9% of children aged 5 years and 20% of children aged 11 years are classified as obese. To stop the 9% becoming the 20% an investment of £1m is needed. This would pay for family-healthier lives and early lives programmes, which would give both immediate and longer-term benefits.

**Response:** Groups were reticent to fund this initiative to the full amount. They felt there was already a lot of health information about this and that parents should be taking more responsibility for setting a good example. There was also a feeling that this was a national issue and funding should come from the Government to schools to educate and also to monitor the food industry.

**Question:** About a third of the population have a health condition such as diabetes, heart disease or mental health problems. A long term investment in the public health programme would encourage people to look after their own health and would help to reduce the pressure on health services from these conditions. Invest £1m to encourage behaviour change and help people to live healthier lives.

**Response:** People were cautious about giving money just for promotion although one group did say they felt more information was needed to help people-. They would spend it on education and help schemes but would want full evaluation.

**Question:** The estimated annual health cost of passive smoking on non-smokers is £2m. Invest this to promote outdoor smoke-free places – parks and playgrounds,
which would help to prevent future generations take up smoking as well as to reduce the £2m health care costs.

**Response:** Groups wondered how this would be monitored and were concerned how much this could cost. People thought this was a lot of money and did not feel confident that it would work. There was a further concern that it might actually force people to smoke indoors and hurt the health of youngsters in the home.

**Question:** There are approx. 15,000 people over 65 in Wakefield District. 30% (4,500) of them may experience a fall and would benefit from a ‘targeted’ exercise programme at a cost of £100,000. By investing in this programme there is the potential to prevent over half of these people from a further fall. This would reduce A & E attendance at a cost of £90 per visit – thus saving approx. £200,000 per year.

**Response:** Most of the comments here were about how the programme would help people, how they would be identified, who would help, how would it be evaluated. There was discussion about providers only being paid by results. Although 4 groups funded this another two thought the support could come from current services/public health. One couldn’t make a decision.

**Question:** There are approx. 22,000 people in Wakefield aged over 40 year who are overweight and at a high risk of developing Type 2 diabetes. An investment of £1m into a range of services to promote healthier lifestyles could help to reduce the number of people developing it and reduce the rising cost of managing diabetes.

**Response:** Groups felt that this information was already “out there” and that any further work should be undertaken at a national level as it is a national problem. Issues such as food labelling and tackling drinks companies were suggested. Again they were not sure if this type of initiative worked. However, two groups did feel that this would help swimming pools and other facilities stay open/we were educating to save and did decide to fund it.

d) **Finance & efficiency**

**Question:** A private healthcare provider offers to run orthopaedic/physiotherapy services in the district at a reduced price to that currently paid by the CCG. You can
choose to change your provider to save £2m. The existing service currently costs £10m.

Response: This question only came up for one group but they were happy to make this change as long as the service was of a good quality.

Question: Stop the prescribing of medicines that can easily and cheaply be bought from supermarkets or pharmacies for minor conditions. Save £300,000 per year on Primary Care Prescribing.

Response: People thought it should only cost the NHS the same price as people pay for cold remedies, paracetamol etc in supermarkets. All agreed to stop prescribing these drugs.

Question: Stop prescribing gluten free food products that can be bought readily in supermarkets with good choice. Save £200,000 on Primary Care Prescribing.

Response: Groups were shocked by how much the CCG spent on this and felt that people should pay for these themselves. They felt that these products were now more widely available at reasonable cost and was part of self-care. However, there was concern for those who would not be able to afford the essential products like bread and people thought coupons might be used.

Question: The National Institute for Health and Clinical Excellence (NICE) recommends three rounds of IVF treatment. At the moment Wakefield provide one round for couples with fertility problems. This costs on average £3,550 per couple/per round. To offer 3 rounds would cost an additional £200,000. Should we change from one round of IVF?

Response: Most groups said that this was the most difficult decision to make. Many could not make a decision. Two groups thought we should stay at one cycle whilst another increased to three cycles. Two groups had to take a vote 10 said one cycle and 5 said 2 or more cycles. There were comments about the 18 year lower age limit being too low. There were questions about the success rate and whether this improved with further rounds of IVF. Whilst some people thought this must be a very distressing situation others thought it wasn’t a health issue.

“I wouldn’t have IVF in the NHS.”

“The ability to have a child is great but some things are or aren’t meant to be.”
**Question**: A new product has been launched that is similar to the one currently used for the treatment of rheumatoid arthritis in hospital. Locally, the hospital specialists are a bit wary as it is a new kind of product. However, assurance has been gained from both NICE and the European Medicines Agency. Switching patients to this new product would save £500,000.

**Response**: All five of the groups that discussed this question felt that the switch should be made to save the money.

e) **Care & Quality**

**Question**: The CCG has £2.4m to keep health systems and services working throughout the year and specifically to deal with the added pressures of winter. Which services would you choose to invest in?

**Response**: All groups that discussed this question divided the money. Most groups felt that people automatically went to A&E and therefore some money should go there. They also gave money to the Ambulance Service for paramedics to treat people in, or close to home rather than taking people to hospital. One group gave money to primary care and another to voluntary sector and a new service to diagnose and signpost to appropriate services.

**Question**: The CCG has a duty to ensure patients’ rights under the NHS Constitution are met. One of these is a maximum 62 day waiting target for the length of time suspected cancer patients wait between their GP’s urgent referral to specialist and the start of their first treatment. Waits are still too long for diagnostic tests. Clinicians tell us that patient care and outcomes would be better if we invested £1m in more scanning facilities.

**Response**: The groups that discussed this question were in favour. They felt that people shouldn’t have to wait for tests to diagnose cancer. Early diagnosis can make a real difference to outcomes and to money spent on acute care. There were queries about this being a one off cost or recurring. One group was also concerned if the additional service would be private. There was a comment about cancer being diagnosed but then the medication not being funded.

Diagnosing cancer “The not knowing is the worst part”.
Question: Invest £200,000 more in the patient transport service to improve the number of people who arrive on time for their healthcare appointment.
Response: Groups were reluctant to fund this. They felt that patients should use other forms of transport where possible and that the NHS could look to the voluntary sector to provide additional services.

Question: Business cases have been received for three priority areas. We have £200,000 but only one can be funded and only for one year: Option 1 increase short term capacity to reduce the waiting list for diagnosis of Autism Spectrum Disorder for children; Option 2 increase short term capacity in the Memory Assessment Service to reduce the waiting time for a diagnosis of dementia; Option 3 invest in a Street Triage service to improve the care of people experiencing a mental health crisis and give an alternative to being brought to Fieldhead Hospital.
Response: Groups found it very difficult to decide between these priority areas. They felt strongly that all cases affected families, friends and services as well as the patient. Two chose the ASD, one could not decide. Another group took a vote and ASD received most votes followed by dementia.

f) Workforce
Question: The Health Secretary has outlined his plans to reform doctors’ contracts in the NHS. This includes improvements to seven-day working across the NHS. It will ensure that consultants and junior doctors are not expected to work excessive hours. This will cost £1m. It will give better outcomes but where do you get the money from?
Response: There was agreement that doctors work hard. One group felt this should be centrally funded but did agree more care was needed at weekends both in A & E and GP surgeries. A discussion followed about having a “blanket” approach to extended hours. There was discussion about GP contracts and how the CCG could ensure Practices adhered to their contract. There were mixed feelings about the Walk-in centre, from it being essential to being a fragmented service that did not serve everyone.

“There needs to be extended hours to reduce A&E”.
**Question:** Following the Francis Inquiry, NICE produced guidelines to help providers and commissioners implement “safe staffing” levels in the NHS. In June 2015 NHS England announced that this would now be taken forward as part of a wider programme of service improvement. Your local trust requires £800,000 to meet the hospital targets.

**Response:** There was discussion about safe staffing ratios. One group felt it was a trust problem, and that they should look at their retention not recruitment. One group discussed having fewer managers in the NHS to pay for this. The discussion revolved mainly around where to take the money from eg “Care closer to home popular with patients but catch 22 – need the services before you can draw funds from hospital but in the meantime hospital needs money to provide the service”.

“This is the kind of thing the public don’t hear, its scandalous to have to take from one into another – I would happily pay more income tax to cover this”

**g) Digital**

**Question:** New technology exists that can help health and social care services provide a greater continuity of care for individuals and reduce their risk of admission to hospital. Invest £1m to save £5m over the next 5 years.

**Response:** This question was discussed by three groups. One felt that the CCG were not in a position to fund new services and that evidence would be needed to ensure the investment was worthwhile. They decided to fund a £100,000 pilot. Another group felt more information about the benefits was needed and that “the NHS doesn’t do technology that well”. They did however fund it. One group thought that this was a good long term investment and fully funded it.

“This is the kind of thing the public don’t hear, its scandalous to have to take from one into another – I would happily pay more income tax to cover this”
6. **Where did people take the money from?**

On the whole people took the money from where they felt a service might make savings due to the benefits eg social prescribing was often funded from primary care or community care as it was felt if the scheme was successful these services would be used less.

If “in year savings” had already been made money might have been taken from there or, where the funding was a “one off” payment it was taken from non-recurrent funds.

However, where this was not obvious people often took the money from prescribing as they felt there was still a lot of wastage in the system and efficiencies to be made.

7. **What did we all learn?**

It was clear from the beginning that the discussions were as important as the decisions made during this process. Playing the game often raised more questions rather than answering the specific questions presented. People came up with some good ideas. One person mentioned that the state pension age has changed but the pension exemption age on prescriptions has not. On occasion savings were made as a result of decisions. One group commissioned a new Telemedicine project in Wakefield with their £100,000 savings.

CCG colleagues at the events found that people were aware of the difficulties the NHS faces. But there were lots of questions about who held different budgets and about different providers of services. Some people were unaware that GPs are not employed directly by the NHS but instead have a contract with the NHS (CCG in Wakefield district) and usually own their own premises.
We heard how important people feel prevention and communication are to success and also that monitoring and evaluation should be core to our work. One group in particular felt that the constant changes in the NHS wasted money and that generally there was still unnecessary waste.

It was clear that the decisions that the public found hard were the same as the ones the CCG found most difficult. These were around the IVF funding and choosing between three projects to fund when all seemed essential and had a wider impact than just the patient, ie dementia, ASD, mental health crisis. Overall people found the consequences of their decisions difficult.

8. What we will do next

There have been a number of suggestions of groups that might be interested and benefit from playing the Commissioning Maze Game. The CCG is happy to facilitate further sessions and continue to collect feedback.

The feedback we have received so far will help in the development of the Sustainability and Transformation Plan for the CCG. This report will be posted on the CCG website and intranet and we will feed back to groups we have visited, especially where this has influenced our decisions.

The CCG is investigating the possibility of developing an online version of the Commissioning Maze to reach a wider audience and gain more feedback.

NHS Wakefield CCG would like to thank all those who have been involved in the work, the public, stakeholders and our staff.
The Commissioning Maze – Rules
The rules are quite simple, but the challenges you face during it may not be.

Imagine you are one of the health bosses at your local Clinical Commissioning Group. Your task is to decide the best way of spending the health budget in the area. What is important to you? The health and wellbeing of local people depends on your decisions!

Each table should have a facilitator, who will make notes about your decisions and give background information.

You’ll each have two boards on your table; the Maze Board and the Money Board.

Maze Board.
• You should have a counter to move around the board and dice to begin
• The hexagons are colour-coded to represent the six piles of scenario cards at the top of your Maze Board.
• You begin the game by rolling the dice and moving your counter from the start position clockwise depending on the number shown on your dice.
• Whatever colour hexagon you land on, you should pick the top card from the same coloured scenario pile. Read the card to your group and then discuss.
• There is only one coloured scenario where the instructions are mandatory, and that is the red cards (National and Local Policy). The other scenarios are optional; however when making your decision, always consider the consequences of your actions. Check with the facilitator if necessary.
• After each turn is complete, a member of your team should pick up a Consequences card from the centre of the Maze Board and read it out to the rest of the group. This is for information only and no action is required.

Money Board:
• Nominate one person to be responsible for the Money Board, to avoid confusion.
• The budget will already have been allocated according to the current spend list on the board. This is only indicative, as you can choose to move money around during the exercise.
• You should have a separate pile of “New Money”, which you dip into only when you land on the hexagon “In The Black”.
• You also have three extra boxes on your money board: New Services, Prevention/Public Health, and In Year Savings.

**New Services** – If you have any additional money you may want to put it into this box and discuss which new services are desirable. Are there any gaps you want to fill?

**Prevention/Public Health** – Whenever you land on the hexagons for Prevention or Public Health and you choose to proceed as the instructions on the card, you should place the correct amount of money into this box.

**In Year Savings** – At various stages throughout the exercise, you may make some savings in the same financial year. If you do so, please place the correct amount of money into this box.

You are free to use any monies contained within this box to commission new services or increase the funding to existing services.

You will be allowed a maximum of 75 minutes for the exercise, after which each group would be requested to provide some feedback about your overall experience and your most challenging decision.
We’ll then wrap up with a bit of an overview from the CCG about the realities of commissioning and how challenges such as the ones you have just experienced are overcome.