

The Changing Commissioning Landscape

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Commissioned by NHS Clinical Commissioners

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of clinical commissioning groups

Contents

Executive summary.....	3
Introduction.....	4
Methodology.....	4
Survey findings.....	5
New care models.....	5
Opportunities.....	7
Risks.....	8
Commissioning arrangements.....	9
Integration	10
Strategic commissioning.....	10
Capacity and capability	11
Support needs.....	12
Key themes from the interviews.....	13
Present developments.....	13
How is the STP working?.....	15
How does it feel on the ground?	16
Success factors.....	17
Obstacles and risks.....	18
Support and enablers.....	20
The future of commissioning.....	21
Succession planning in commissioning leadership.....	23
Summary analysis and conclusions.....	23
Annex A: List of interviewees.....	27

Executive Summary

In March 2017, NHS Clinical Commissioners undertook an on-line membership survey and commissioned a series of interviews with CCG leaders to gain greater clarity on the changing commissioning landscape. Survey responses from 43 CCGs and interviews with 14 commissioning leaders yielded data on what changes are taking place locally and on commissioners' support needs.

In the survey, 77% of respondents indicated they were planning to contract for a new care model in 2017/18; 74% felt their CCG understood the opportunities presented by new care models. All respondents envisaged risks with contracting for a new care model, including a lack of evidence around operations and efficacy, and regulatory requirements not keeping pace with developments.

Nearly all respondents were in collaborative commissioning arrangements with one or more CCGs, and 72% said they were planning to increase their level of collaboration in 2017/18. Some 40% shared an accountable officer with at least one other CCG, and 16% were planning a formal merger with one or more CCGs.

Just over half of respondents reported that their CCG had the capacity to undertake strategic planning for population health; 44% said they did not. Several capabilities were flagged as gaps, including longitudinal analysis, data gathering and analysis, legal expertise and organisational development. Many noted their greatest problem as capacity, not capability. Amongst support requested were quick dissemination of best practice in new care models, including contracting and adverse consequences; a single system-based regulatory and assurance framework; a lighter administrative burden; and leadership development.

The interviews showed that all areas were taking forward changes to their commissioning and/or delivery mechanisms. CCG leaders on the whole thought that STPs could be a useful catalyst for change, whilst also being concerned about their uncertain legal status and sometimes nebulous governance. Four future landscapes are developing amongst current CCGs: CCGs operating across larger footprints as strategic health commissioners using STPs as a key vehicle for delivery; integration of healthcare commissioning with local authorities; developing an Accountable Care System (ACS), and developing an Accountable Care Organisation (ACO). Interviewees overall saw strategic commissioning as the destination of CCGs, and clinical leadership and commissioning as vitally important to preserve.

The morale of commissioning leaders was higher than anticipated, but there was also frustration expressed about the perceived lack of policy clarity on ACOs, ACSs, and strategic commissioning. There was a wish for greater policy direction in these areas, as well as a new single place-based regulatory framework. In terms of support, views were split whether the centre should focus resource on the needs of today's commissioners, or those of tomorrow's, but areas of need included legal expertise, knowledge sharing and succession planning.

Introduction

211 Clinical Commissioning Groups (CCGs) were created in April 2013 through the introduction of the Health and Social Care Act (2012). As clinician-led statutory bodies constituted by their member GP practices, they were different in kind from their predecessor bodies, Primary Care Trusts. The legislative framework for healthcare commissioning has remained basically unchanged since the inception of CCGs, yet much change has nonetheless been ushered in through new national policy programmes, including devolution; the creation of new care models; primary care co-commissioning; and the introduction of Sustainability and Transformation Partnerships (STPs) and the focus on place-based commissioning and delivery of healthcare. A fundamental fact in these developments has been the severely constrained fiscal context of all public services, including health and social care; another has been the centre's atypical encouragement of a proliferation of different models, leading to a perhaps unprecedented mix of commissioning and delivery models in the NHS.

In this context, CCGs have changed and developed in multiple ways and directions. To chart these developments, NHS Clinical Commissioners (NHSCC) initiated a membership survey in March 2017, followed by a number of in-depth, interviews with commissioning leaders across the country. The aim of these exercises was both to get greater clarity on what is taking place locally in response to these national policy initiatives, and to better understand what support CCGs might need to succeed in their roles.

Methodology

NHSCC conducted an online survey where all accountable/chief officers were invited and encouraged to participate. The survey consisted of 23 questions—a mix of multiple choice and free text—and asked each respondent to identify themselves by name, organisation and region. A total of 34 responses was received, of which seven were from chief officers of more than one CCG. In total, there were therefore responses from 43 CCGs out of 209¹, or 21% of all CCGs.

Thesis 11 was contracted by NHSCC to analyse the survey results and conduct a series of further interviews. In the exposition that follows, where percentages from the survey don't come to 100%, this is due to rounded up numbers or one or more respondents leaving that question blank.

Alongside the survey, Thesis 111 undertook a series of in-depth, interviews with commissioning leaders. Fourteen commissioning leaders out of a long-list of twenty-two were interviewed: five of the interviewees were CCG chairs, and nine were accountable officers or chief clinical officers. Two of the interviewees were also STP leads in their respective patch. Interviewees were drawn from a mix of high

¹ From 1 April 2017, this became 207 CCGs

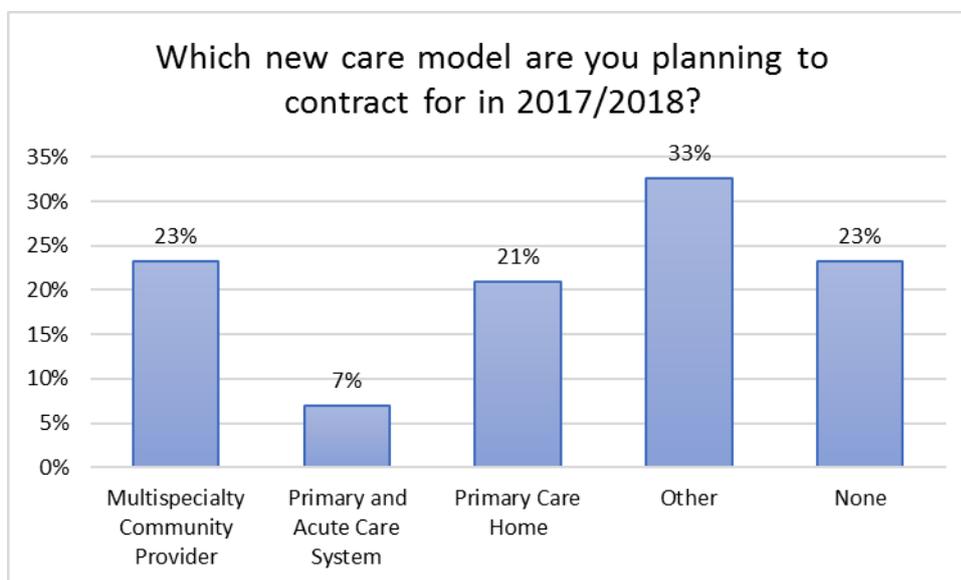
performing and struggling CCGs, between them taking forward several different new commissioning and provider models. A list of interviewees can be found at annex A.

Survey findings

New Care Models

From the inception of the Vanguards to more recent developments around Accountable Care Organisations (ACOs) and Accountable Care Systems (ACS), and based on the published plans of STPs, it is clear that a number of new care models are under way across the country. NHSCC wanted to test what new care models are being contracted for, and the appetite for developing new models.

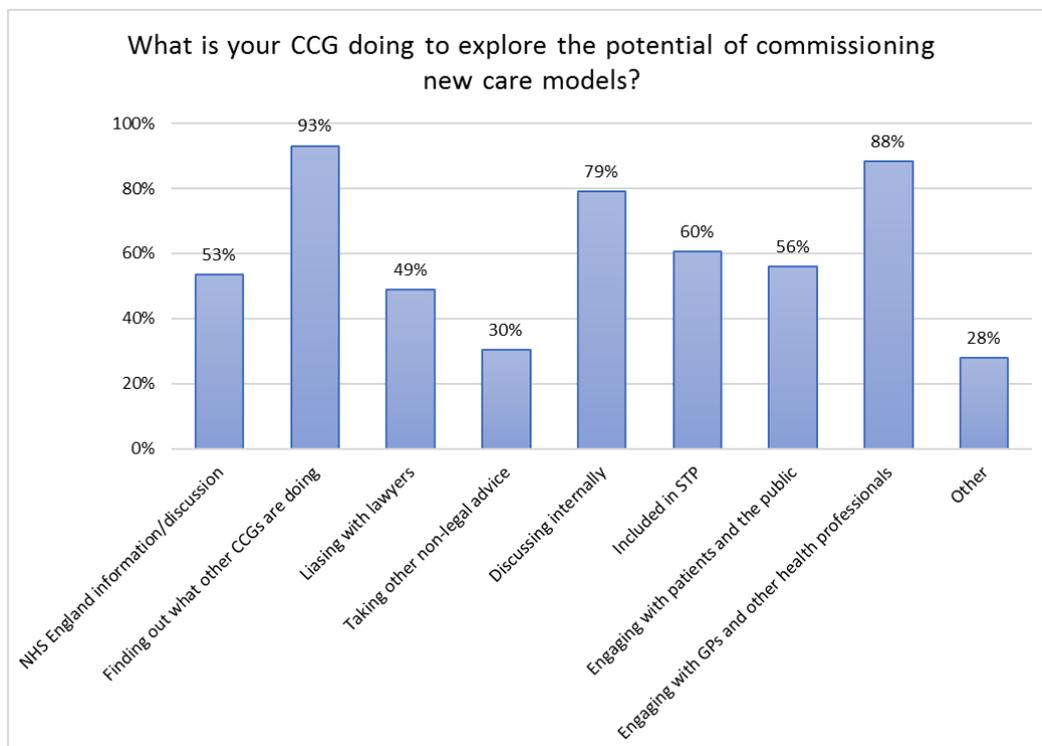
Respondents were asked which, if any, new care models they were planning to contract for in 2017/18, with a menu to choose from: 77% of respondents said they were planning to contract for a new care model in this financial year. Roughly a quarter (23%) of respondents indicated they were going to contract for a Multispeciality Community Provider (MCP), whilst 21% ticked the Primary Care Home option. Perhaps surprisingly, only 7% indicated they were going to contract with a Primary and Acute Care System (PACS); whilst 23% were not going to contract with any new provider model. A significant proportion of respondents (33%) had plans set for potential new models of care other than the options listed in the survey question, with an indication that many of those plans may concern an ACO or ACS.



When asked whether they would be interested in pursuing one or more of these new care models from 2018 and beyond, an overwhelming 84% answered yes, with 12% indicating they did not know, and only 2% saying no. It is worth noting that out of the initial 23% who has said they would not contract for a new care model in 2017/18, 80% said they would wish to pursue a new care model in future (from 2018 and beyond), and 20% said they did not know.

In terms of commissioning footprint for these new contracts, respondents were asked to indicate at what level/s the new care model/s were being developed, with the majority (56%) indicating that this was the CCG footprint level. A significant minority (16%) suggested that it was on a footprint smaller than the CCG's, whilst 14% said it was across the boundary of one or more CCGs. A somewhat smaller number (9 %) said it was across more than one entire CCG footprint, and 5% indicated that it was at STP level.

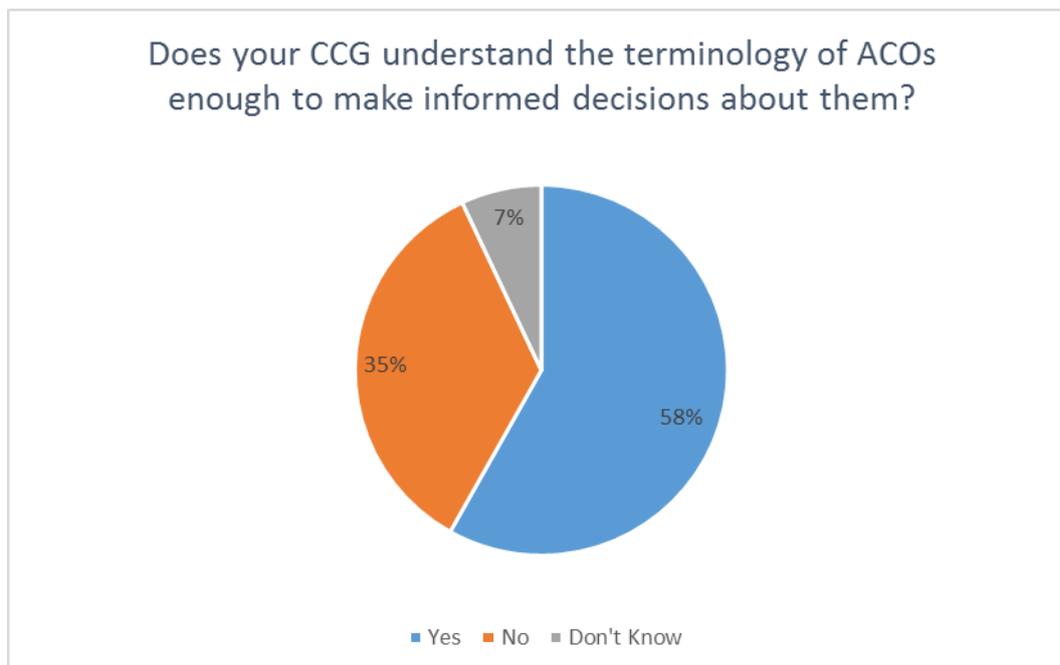
Respondents were also asked what they were doing now to explore the potential of new care models, with the options of ticking more than one answer. Almost everyone (93%) indicated they were finding out what other CCGs were doing, whilst a strong majority (88%) were engaging with GPs and other health professionals on the matter. Nearly as many (81%) said they were in internal discussions about it, and 60% indicated that these explorations formed part of their area's STP plan. Just over a half of respondents (56%) were engaging with patients and the public about new care models, whilst 53% were in discussion with NHS England. Almost half (49%) were liaising with lawyers, and nearly a third (30%) were seeking other non-legal advice. Another third, or 28%, ticked the 'other' option, and in their free text elaboration, many—63% of those who ticked the 'other' option—described how they were working with their local authority on options around new care models. More than a third (36%) of those who ticked 'other' said they were discussing or working with their local providers, and one respondent highlighted being part of a Nuffield Trust learning set around these issues.



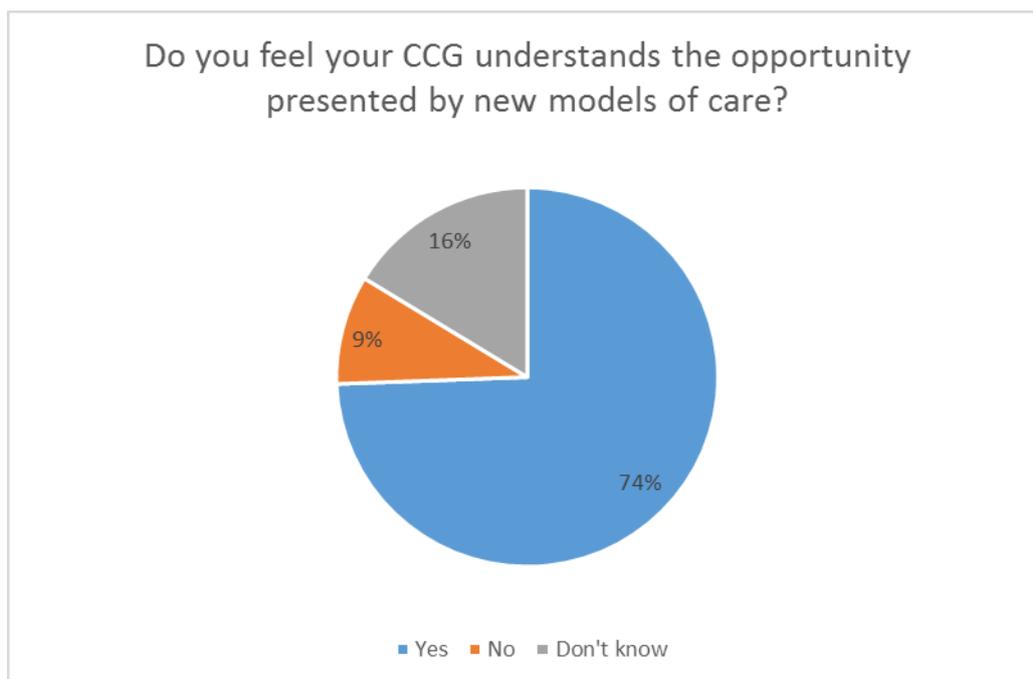
Opportunities

The development of new care models such as ACOs has brought about national and local discussions about the future role of commissioning. Part of the discussions have concerned the development of 'strategic commissioning' and the assumption that some current CCG activity would move, or be delegated, into a new type of integrated care model. NHSCC wanted to better understand how commissioners see and understand these possible developments.

Respondents were asked if they were clear on what current CCG activities could move out of the CCG and what functions must be legally retained by the CCG, with 51% stating they were clear; 21% saying they were not clear, and 26% saying they were not sure. With regard specifically to ACOs, respondents were asked whether they felt they understood the range of terminology associated with ACOs enough that they could make an informed decision about them now, with 58% of respondents answering in the positive; 35% of respondents answering in the negative; and 7% saying they did not know.



Regarding opportunities, respondents were asked whether they felt their CCG understood the opportunities presented by new care models, and a strong majority (74%) said they did; only 7% said they did not; and 16% said they did not know. One respondent noted they were not clear on the balance of opportunities versus risks, and a couple wrote that they believed they needed to work this through in greater detail, noting that whilst the theory was clear, the practical side, including contractual issues, was much less so: *"[we] need to understand contractual issues further as well as governance to support [the] move to new models of care"*. Another respondent wrote, *"the fear is that we know what we know, but not what we don't know."*



Risks

When asked whether they envisaged any risks associated with contracting for new care models, 100% of respondents answered in the affirmative. In expanding on this, one respondent highlighted that *“[t]here is a lack of evidence that these models are the panacea we are searching for. Just changing a structure will not deliver transformational change.”* About 10% of respondents noted that many of the new models are ‘unproven’ and possibly based on flawed assumptions that what works elsewhere would necessarily work here: *“[It’s an] as of yet untried model of care [which] could have unintended consequences; [and there may be] difficulties lifting a model from elsewhere and dropping it into a free at the point of access healthcare system.”*

Some respondents (14%) flagged as a top risk that successful implementation depended on a different investment model and additional capacity:

“[success is] predicated on investment in self-care, prevention and primary and community care. System pressures are unlikely to allow the required investment...[It also] requires capacity in the system for change, particularly if GPs are to be integrated in any meaningful way.”

Respondents also mentioned the fragile financial position of their key providers and/or local authority as a key risk and, linked to this, the fragility of some system risk shares. Some (12%) flagged provider readiness (both hospitals and GPs or GP federations) as a key risk, and one noted the risk of destabilising the provider system through imposed procurement exercises. Several respondents wrote about concerns about capacity in primary care and 9% noted the level of uncertainty about how new care models would work in practice, with the same number expressing a concern about the level of distraction caused by the change programmes. A couple of

respondents highlighted the relationship to the STP as possibly being jeopardised, without detailing how this might be the case. Finally, 12% of respondents noted as a key risk that regulatory requirements were not keeping pace with the changes and that *“NHSE and NHSI will not be able to support a single, shared place-based bottom line and assurance process.”*

Commissioning arrangements

NHSCC wanted to understand how, and to what degree, commissioners were collaborating with each other and with their local authority and other STP partners, as well as whether there were any plans for CCG mergers on the back of the recently lifted NHS England moratorium on CCG mergers.

Respondents were asked what, if any, governance or management arrangements their CCG currently shared with one or more CCGs, with 90% responding that they were engaging in collaborative commissioning activity in addition to ambulance services. Just over two thirds (70%) stated they had one or more joint committees, and 63% said that they had one or more joint teams. Well over a third of respondents, (40%) indicated they shared an accountable officer; only a single respondent stated they had no collaborative arrangements at all in place. In terms of how many CCGs were part of these various arrangements, the answers ranged from 2 to 12 (in Greater Manchester) to 32 (in London), with the majority indicating they had different commissioning footprints for different types of services.

Regarding plans to increase the current level of collaboration enjoyed by responding CCGs, 72% said that they planned to do so in 2017/18, whilst 14% said that they would possibly do so, and 14% said they had no such plans. In response to whether collaboration in any of these ways improves the ability of CCGs to execute their functions, 77% said they thought it did; 7% said that they did not think so; and 7% said that they did not know.

Regarding formal mergers between CCGs, respondents were asked whether their CCG was anticipating making an application for merger with one or more CCGs in future, with 51% stating they were not; 30% saying possibly; and 16% saying yes.

When asked whether any of the CCG’s activities were transferring to the STP level, 56% of respondents said yes, and 42% said no. In elaborating on this, it was clear that for many this was still work in progress: *“we are exploring this at the moment”* and *“nothing currently, but we are reviewing.”* One respondent wrote, *“transferring is not the term we would use—we are working in a whole system way with all partners encompassed by our STP footprint.”*

However, some detailed more specific areas that would transfer to the STP level, including specialist services such as trauma; design and transformation of services across the STP footprint; the transactional aspects of primary care commissioning; work on stroke, clinical thresholds and standardisation, and cancer; strategic commissioning of ACO models; mental health; and acute contracting.

Integration

Respondents were asked to describe in their own words how far they felt that health and care integration had progressed within their CCG footprint to date, and there were many varied views. Just below a third of respondents, or 30%, noted that progress was “very little”, “moderate” or “still mostly tentative”; an oft mentioned cause was the difficult financial situation of either or both the CCG and the local authority: *“[Integration] between CCGs and local authority [is] very challenged because of budgetary pressures on councils”* and *“[we’ve seen] good engagement and ambition, however progress [is] constrained by a significant and unsolvable financial deficit.”* One respondent, coming from one of the three “success regimes”, noted that *“the intent is always there, [but] the reality is complex.”*

However, 44% noted good or strong progress, whilst recognising that this was difficult work, in part due to issues of culture, trust, and fear of loss of organisational sovereignty, as well as complicated two-tier local authority structures. One respondent wrote: *“[we are] progressing as a Vanguard both in commissioning and provision but meeting with legislative and cultural problems along the way.”* Another cited obstacle was the current legislation.

However, there were many examples of progress, including a number of joint posts and a joint commissioning committee; a pooled budget for adult health and social care hosted by the CCG and led by an Integrated Care Joint Committee whose membership included councillors and GPs; an Accountable Care Partnership Board; joint provision arrangements across health and social care; information sharing progressing (albeit *“with a long way still to go”*); and two CCGs noting *that “coming towards the end of a 150 week galvanising transformation programme, we are on the verge of fully integrating with social care.”*

Strategic commissioning

Recognising that many CCGs are talking about moving towards “strategic commissioning”, NHSCC wanted to test what CCGs understand by it and therefore asked them to describe what they thought a strategic approach to commissioning meant in practice. Not surprisingly, there were a broad range of answers, with many respondents noting that this would depend on the context and what services were concerned. Well over a third of respondents (42 %) framed ‘strategic commissioning’ in terms of outcomes-based or outcomes-focused commissioning: *“[strategic commissioning is] a very small high level function. A heavy reliance on analytics and data. Focus on outcomes and standards.”* Many also mentioned a capitated, population-based approach: *“population based commissioning of health and care, and outcomes-based capitated commissioning.”*

Others mentioned the need for partnership working and “real” collaboration, including risk shares, assurance and holding to account, and a place-based view of population health and population health planning, as well as meaningful public conversations about the future of services and *“making informed place-based decisions about*

priorities for the local pound in dialogue with the communities we serve.” Several respondents highlighted the size of the commissioning area as being key, with the suggested population size ranging from 500,000-1000,000.

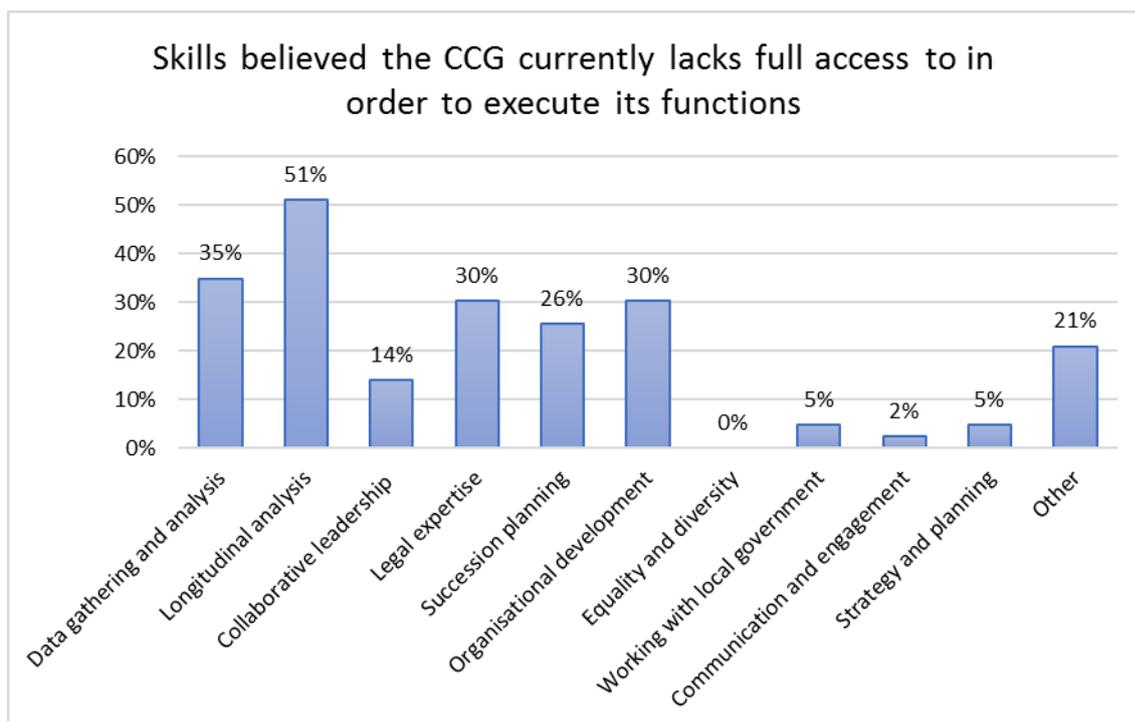
In terms of the level or footprint at which strategic commissioning should take place, most respondents (58%) opted for “multiple levels.” Some (16%) thought the STP level was the right level, and 5% thought it would involve collaboration with one or more CCGs. No one thought the right footprint for strategic commissioning was the CCG, or the neighbourhood. A significant minority of respondents (14%) answered “other,” and the most common example given in the free text box was “supra STP level”.

Capacity and capability

With the evolving changes to the health and care system and the changing roles of clinical commissioners, it seems reasonable to also expect changes in the capacity and capabilities requirements of commissioners. To explore this issue, NHSCC asked some questions about both current and future capacity and capability.

When asked whether their CCG currently has the capacity (including time, skill and resources) to undertake strategic planning for population health (including, for instance, medium to longer term needs analysis, population projections, and longer term outcomes), just over half of respondents (53%) answered yes, with 44% saying no, and 2% saying they did not know. When asked whether there were any skills they thought their CCG currently lacked full access to in order to execute its functions most effectively, 51% of respondents ticked ‘longitudinal analysis’; 35% ticked ‘data gathering and analysis’; 30% ticked ‘legal expertise’, with the same number ticking ‘organisational development’. A further 26% flagged that succession planning was an issue, and 14% highlighted collaborative leadership. It is noteworthy that not a single respondent felt their CCG lacked full access to skills in equality and diversity, and only very small numbers (one or two respondents) flagged working with local government; communication and engagement; or strategy and planning, as a concern.

A fifth (20%) of respondents ticked the box ‘other’, and elaborated on this through free text. Here examples included: IT; research; innovation; partnership working; transformational change; public health; and programme management. A third of those who ticked the ‘other’ box wrote that capacity, rather than access to skills, was the problem. One of them wrote: *“[the] issue is more about capacity than skills—current running cost allowance is wholly inadequate to meet CCG statutory duties...”*



When asked what skills CCGs thought they would need from 2018/19 and onwards, there were a range of responses, but no consensus view. Responses included: partnership working; a far better understanding of population needs; knowledge of social care and local authority working; setting outcomes that can be measured and translate into real change; delivering change at scale; further skills on new contractual forms; gain share approaches; outcomes based commissioning; ability to manage large ACOs; improved business intelligence; OD/workforce capability; system leadership; resilient and agile workforce; greater ability to access and use data; working differently with providers and with local government; population health management; evaluation; and collaboration. One respondent wrote: *“I don’t think it’s about new skills but about not doing the operational level commissioning such as pathway redesign—[and] this may well disengage some clinicians.”* Here too some respondents noted that the issue would not be inadequate skills, but insufficient capacity.

Respondents were then asked whether they had a succession planning strategy in place for their Governing Body level roles, with 65% of respondents answering that they did, and 35% saying they did not. As to whether respondents had had any difficulty in appointing to Governing Body positions in 2016/17, 23% said they had had some difficulty; 74% said they had not; and 2% did not know. Out of those CCGs who did not have a succession planning strategy in place, 13% had also had trouble in appointing to their current Governing Body.

Support needs

Keen to understand the support needs of their members, NHSCC asked respondents what support, from NHS Clinical Commissioners or NHS England, that

their CCG needed to continue to operate effectively in the short, medium and long term. There was a broadly shared and clearly articulated wish from respondents that NHSCC continue in their representative lobbying role, bringing the views and concerns of CCGs to the centre's attention, as well as advice and guidance back to CCGs on new policy and other national developments—including support to understand national timetables for change, and likely and possible future policy scenarios. Further, several respondents felt it would be helpful for NHSCC to offer support such as dissemination of best practice in new care models, contracting and consequences when things have not gone right, as well as help in supporting future models of commissioning and service delivery.

From the centre, respondents expressed a clear and consistent wish for a lighter administrative burden, with fewer data requests, and a reporting and intelligence system in common between NHS England and NHS Improvement to minimise duplicative requests on healthcare systems. There was a strongly expressed view that a streamlined, single regulatory and assurance frameworks for healthcare systems, rather than for discrete organisations, would be enormously helpful. Respondents also asked for greater clarity on national direction of travel and political cover and support for difficult service changes to enable needed local change and transformation. Several respondents also asked for a review of CCG allocations and/or greater financial support and/or transformation funding. There was also a call for a different and stronger approach to leadership development and career support. A couple of respondents noted the need for a change in the procurement legislation.

Key themes from the interviews

Interviews took place in the second half of March, 2017, prior to the NHS England publication *Next Steps on the NHS Five Year Forward View* and the Prime Minister's announcement of an early June general election. Through the interviews, there was an opportunity to explore in greater depth the local developments and future direction of both CCGs and commissioning leaders.

Present developments

From the research, it was evident that all areas are taking forward changes to their commissioning and/or delivery mechanisms, with developments at various stages of maturity. Often these developments form an important part of the area's respective STP plan.

Each of the fourteen commissioning leaders interviewed described changes on the ground with regard to commissioning and/or delivery of healthcare. In many cases, these developments formed part of the corresponding STP plans but had pre-dated the STP itself, such as in Northumberland, where plans for an ACO have long been underway, or in the health economy of North East Hampshire and Farnham, where collaborative work on a joint 5-year strategy started as early as 2012.

Three of the areas—Erewash, Stockport and Dudley—were in various stages of developing an MCP, with Stockport also forming part of the Greater Manchester Devolution coalition. In the South, Kernow was also working towards devolution. North East Hampshire and Farnham, which forms part of the strong and longstanding Frimley Health collaboration, described the creation of a PACS, whilst Sutton in South West London has overseen the successful creation of a care home vanguard.

Several areas—Oxfordshire, NEW Devon, Gloucestershire, Chorley & South Ribble and Greater Preston among them—had made the conscious choice to put off any decision of specific care models in the clear belief that form should follow function, and that it was important to think this through from the bottom up before jumping to any conclusions:

“We haven’t said that we’re working on an ACS or an MCP—we first want to decide what the service model and reconfiguration should be, and then discuss what the organisational form should look like. We’re also in discussion with our STP, and a lot of work has taken place with our district authorities, as well as with GP practices, the third sector and trusts.” Jan Ledward, Accountable Officer of Greater Preston and Chorley & South Ribble CCGs

In Oxfordshire, David Smith, STP lead for Oxfordshire, Buckinghamshire and Berkshire West STP and CEO of Oxfordshire CCG, described how the STP commissioners across Oxfordshire, Buckinghamshire and Berkshire West have come together into a Commissioning Executive chaired by one of their lay members, and the plans to turn this into a formal joint committee. He also described the wider developments across the patch, where the three constitutive areas are respectively developing more local plans: *“Across the STP we have two of our three local health and social care systems developing as ACSs. We will use the learning from these developments to support the ACS discussions which are already underway in the third system. As the ACSs progress, we will also review our current commissioning arrangements.”*

Not having agreed a specific care model does not, however, preclude progress on several fronts. Those CCGs which have yet to embark upon the development of a specific model all described a series of activities, some of which are bringing about integration and transformation in their own right, others of which are exploring the building blocks of a new care model:

“We’re working together in the system, in a bottom up way. We don’t have any ACO or ACS plans yet, but we’re organising our GP practices into clusters in localities, each of which has a board. We’re also working closely with public health and with the council, and also the third sector; we’re developing social prescribing, and other third sector alternatives to medical management.” Mary Hutton, Accountable Officer Gloucestershire CCG and STP lead

Further south, Janet Fitzgerald, chief officer of NEW Devon CCG, one of three 'success regimes' alongside Essex and Cumbria, described the work they've done to move towards a single STP operating plan and control total. Regarding new care models, she said:

"We started to explore organisational form a few months ago in a collaborative board which includes CCG, Local Authority and provider colleagues as well as clinical leads and elected members from across the patch. We are looking at the evidence base in the UK and internationally for ACOs and ACSs—and we're looking at agreed building blocks and system principles."

How is the STP working?

CCG leaders on the whole thought that STPs could be a useful catalyst for change, whilst also maintaining a concern about their uncertain legal status, their sometimes nebulous governance, and their potential difficulty in getting clinicians fully engaged.

Several interviewees acknowledged STPs as important vehicles for large-scale change, and some were optimistic about them. Professor Nick Harding, chair of Sandwell and West Birmingham CCG, which sits across two STPs, said:

... "fundamentally I think the place based agenda and the STPs are an opportunity for good change and for making things better—I think it all depends on how you use that opportunity."

One of the interviewees described the STP as the chance to start reflecting a model of care tailored to the specific context and circumstances of a rural area, as opposed to a generic model, or a model developed for e.g., a large urban conurbation—and the chance to develop the workforce alongside the service model:

"We can start creating our own training and development and to make working here in Lancashire and South Cumbria more attractive, although it's not a metropolitan area—to sustain and develop our workforce for the future is probably the main benefit of the STP process" Jan Ledward, Accountable Officer of Greater Preston and Chorley & South Ribble CCGs

Some interviewees believed that the STP has helped push through a necessary set of developments, or to speed things up, as in Gloucestershire:

"I think the STP has enabled us to accelerate the work we had already started in the transformation of services. The participation and leadership of providers have been really beneficial, and the engagement of both managers and clinicians" Mary Hutton, Accountable Officer, Gloucestershire CCG and STP lead

There was also recognition from a couple of interviewees that the STPs, where they usher in economies of scale, can bring a number of benefits. Amanda Bloor, Chief Officer of Harrogate and Rural District CCG, said: *"Whenever you do things at a greater scale, there's opportunities to find efficiencies and to drive out unwarranted*

variation—and there are opportunities here also of considerable savings in running costs.”

However, there were also several concerns expressed about the STPs’ lack of ‘statutory legs’ which was perceived to undermine their authority and consequently their effectiveness. Several interviewees remarked on the STPs’ uncertain role and position, with one commenting, *“Everyone talks about the STP like it’s a magical thing—but it’s not really a thing yet—and we don’t actually know what it will be yet either.”*

More than one interviewee described the perception of the STP ‘on the ground’ in less than a positive light: *“Locally, the STP feels like a very top-down reorganisation, a management re-configuration. People haven’t coalesced around the STP concept—it has no traction with clinicians in primary or secondary care. Locally, some people are waiting for the STP to fail.”*

Some interviewees noted a concern about the lack of accountability in the STP and a democratic deficit in its decision-making. One deplored the lack of transparency in the national STP process and how the timelines had made local public engagement nigh on impossible.

How does it feel on the ground?

The interviews explored with CCG leaders how they and their organisations felt considering on-going local changes. One or two interviewees expressed worry and anxiety about “being done to” and the fact that charting one’s own course is far from straight-forward considering the speed of change and what was felt to be an obscure destination. However, they were nonetheless pragmatically grounded in the sense that *“we just have to get on and get the job done”*.

The great majority of interviewees were clear that they felt like they could, and were, charting their own course and destiny, whilst being realistic about the extent to which the level of uncertainty about the end state causes anxiety and worry for many members of staff. It was telling that many felt that they could forge ahead and create their own solutions to sometimes intractable problems—and several spoke enthusiastically about local assets and enablers. For instance, Dr Andy Whitfield, chair and clinical lead of North East Hampshire and Farnham CCG, noted the many positives in the local system, including very high calibre lay people; excellent local relationships, including with local authorities; and vanguard funding, and stated, *“...we decided to be at the forefront of all this change to ensure the future destiny for our patients.”*

Many interviewed leaders highlighted their current strong personal focus on their staff, both clinical and managerial, and the work to support and motivate them in what feels like challenging times. Some noted that the very frequent and often negative media coverage did little to lift people’s spirits locally, and wished this could be different.

Success factors

Interviewees were asked to describe what had gone well, and many gave detailed examples of the perceived contributing success factors. A number of success factors were identified, including some external ones (natural geography, absence of historic debt), as well as stable leadership and clinical leadership, and some specific qualities of individual leaders.

Having started the transformation journey early—in other words, having sufficient time to undertake massive change programmes—appeared to be a clear condition for success. A couple of the more developed systems amongst those interviewed, Frimley and Dorset, both started their system-wide collaborative working much earlier than the STP process or even the publication of the *Five Year Forward View*.

Stable leadership (not just in the CCG, but also in surrounding organisations, including local authorities) appeared in the interviews as a strong predictor of success, with some specific leadership qualities emerging as vital. These qualities include: having an open mind and a willingness to explore and embrace the unknown; resilience and a ‘can do’ attitude, coupled with a strong belief that seemingly conflicting views and demands can be resolved and overcome; and a single-minded focus on the prize coupled with an ability to engender and nurture trust and a culture of respect.

Interviewees particularly highlighted that strong, continuous clinical leadership and engagement, with primary care and hospital based clinicians working together, made both progress and success more likely:

“A really positive thing is the delivery of our vanguard, with changes to how general practice work and how patients are being managed—and this is down to local leadership by clinicians”. Rakesh Marwaha, Accountable Officer of Erewash CCG

Clinical commissioning was also singled out as an important condition of successful change:

“The clinical aspect of commissioning has made a significant difference—in our case, we can see this in the centralisation of stroke services, and the reconfiguration of acute hospitals. Also the development of the Greater Manchester strategic plan, which later became the STP, was heavily engaged in by clinical commissioners”. Dr Ranjit Gill, Chief Clinical Officer Stockport CCG

Two external factors emerged as pivotal to the success or failure of a local healthcare system: natural geography, and legacy debt. Natural geography can be a strong predictor of success for a practical reason (e.g., providers can more easily collaborate and share staff, facilities and services), but also for the psychological reason that if a system naturally thinks of itself as one, many battles have already been won, for instance, as in Dorset:

“We know we’re ahead of the game, but we have benefitted enormously from our natural geographic footprint: we see ourselves as one and always did, and it’s a tremendous help and advantage.” Tim Goodson, CO Dorset CCG

Not being weighed down by historic debt is a clear indicator of the likelihood of success, mainly because it frees the local system to focus on transformation and innovation, and doesn’t take precious capacity away to ‘feed’ regulators and assurance processes.

Obstacles and risks

Interviewees described obstacles and risks that ranged from moving past organisational boundaries, current legislation and unfortunate natural geography to excessive or flawed regulation and lack of policy clarity from the centre. However, the greatest risk as the country moves forward with new care models and changes to commissioning was seen to be the possible loss of clinical commissioning and clinical engagement and leadership.

The relatively recent STP requirement for local healthcare systems to be jointly responsible for a place-based control total necessitates a mindset exceedingly different from what has gone before. The need to look beyond organisational boundaries and budgets has to many been tremendously challenging. Not surprisingly, where relationships aren’t particularly strong or longstanding, this difficulty is exacerbated, as exemplified by some of the interviewees.

However, several of the systems represented by interviewees seem to have made good progress in transcending organisational boundaries and self-interest in the recognition that:

“[t]here’s no point in one organisation being successful if others aren’t. Patients don’t care about this: they want good, joined up care”. Dr Andy Whitfield, Chair and Clinical Lead, North East Hampshire and Farnham CCG

Regarding new care models, several interviewees worried that a strict focus on organisational form and on becoming an X or a Y organisation was a distraction that took attention away from the real task of understanding population need, and the redesign of services to meet those needs. Some were clear that they thought that becoming an X or a Y had become an end in itself, rather than a means to the real purpose of meaningful transformation.

Just as natural geography can be a contributing success factor, it can be a real obstacle—e.g., in Cornwall, where the geography makes acute collaborations next to impossible:

“We have a very difficult set of finances in South West Cornwall—we are not too far behind Devon. Either the healthcare system simply doesn’t work in South West Cornwall—or the metrics are wrong for us. It’s a long, thin peninsula—the

geography is very difficult in terms of sustainability of services. Trusts aren't close enough that they can meaningfully collaborate, either in terms of sharing or supporting fragile services or a difficult A&E spell, or by otherwise sharing staff or doing joint appointments.” Dr Iain Chorlton, Clinical Chair, Kernow CCG

Many interviewees noted that the current legislative framework, which was intended for independent statutory bodies set up to compete with other such bodies, is in direct opposition to the deep collaboration now required by both commissioners and providers in the challenge to move from a tariff-based payment system to an outcomes-based model and capitated accountable care:

“Competition rules are a nightmare. Something needs to be done about the legislative framework. The whole statutory system is set up for you to work independently in competition with all others: but this is entirely at odds with what we're trying to do now”. Tim Goodson, Chief Officer, Dorset CCG

Interviewees deplored the time, effort and money required to “work around” the legislation—and some were keen for a national steer on how this is meant to be handled locally.

Paul Maubach, CEO of Dudley CCG, in describing the change programme to create an MCP, reflected a point which others touched on as well:

“the biggest risk is that in the past decade we have created a system that is too reliant on hospital care and puts too much resource into hospitals—we need to reverse that now, and this creates a big risk for hospitals. We need to alleviate this somehow, but how? We can't risk completely destabilising them.”

Many interviewees listed the lack of clarity between the roles of NHS England and NHS Improvement as a major obstacle, with reports of contradictory “marching orders” at local level, and sometimes diametrically opposed local views, e.g., regarding whether to live by an STP's control total, where some acute trusts seem to have had strongly worded advice from NHS Improvement that flew in the face of articulated system aims.

Along similar lines, the current regulatory regimes were described by many as not fit for purpose, and/or excessive. It was strongly noted that we now needed a system approach to regulation, and that this approach could not come too soon.

Additionally, it was clear that sometimes insufficient risk appetite and backing from the centre can be a stumbling block for local progress:

“At times, I think there's some concern at the centre about setting things free and running new models—the failed contract in Cambridgeshire has cast long shadows. The sense is very much ‘we can't have another Cambridge’. And there isn't a massive risk appetite centrally because of the state of the NHS's finances which is

paradoxical—given what they're asking us to do” Dr Alistair Blair, Chair of Northumberland CCG

Delivering massive change whilst also looking after today's money and performance was seen by several interviewees as a very significant challenge, as was general capacity. Crowded and unsuitable premises and estates were also flagged as stumbling blocks in the need to *“deliver today whilst transforming tomorrow.”*

Perhaps the greatest consensus of any topic across the fourteen interviews was a near universally expressed concern, sometimes in great length and detail, about the risk of losing clinical leadership and engagement as we move towards a new commissioning landscape:

“The greatest threat is the loss of clinical engagement! To me, one of the successes of CCGs as compared to PCTs is a lot more clinical engagement from many more clinicians around the strategic development of services and pathway redesign. The risk now is that GPs feel without a voice and that we'll lose them...we really need to manage and mitigate this to prevent it from happening.” David Smith, CEO Oxfordshire CCG, and STP lead

There was further a strongly held conviction by many, both managerial and clinical leaders, that the 'clinical' in clinical commissioning was the greatest legacy of CCGs and one that must be retained:

“We want to preserve the value of clinical leadership and input into commissioning. Clinicians bring a level of credibility to a plan or objective that otherwise wouldn't be there—the same is true for public engagement.” Dr Iain Chorlton, clinical chair, Kernow CCG

Support and enablers

Interviewees described several diverse enablers and support mechanisms, ranging from greater clarity on national policy positions and new care models, greater access to best practice, and tailored support for CCG staff groups, to a plea for the development of the skills most likely to be required in the emerging new commissioning landscape.

About many of enablers, there was clear consensus, but there was a split view as to whether NHS England guidance was an enabler or an obstacle. Several of the interviewees stated that it was an important enabler, whilst a small minority of interviewees had a strongly held view that the centre should not issue any more guidance or directives but rather let the system unfold on its own.

Those who saw it as enabling said they wished to see brought into public view a set definition and an exposition of e.g. “ACO” and “ACS”; a clear articulation of “strategic commissioning” and of what commissioning functions and activities should and could

sit where in the system; and what services should and could be commissioned at what footprint level.

There was also a request for clarity on the path from here to the end state, with a consistent narrative, and clarification of the end state. One interviewee suggested that there may be, say, four models that health systems could choose from and aspire towards—and that it would be helpful if NHS England and NHS Improvement could agree on these models and make them public. Several interviewees expressed a concern about chaos in the system because of the seeming open-endedness about the end state of commissioning. There was also some concern about the capacity and time required for each system to invent its own form—surely, they thought, there could be national shortcuts here.

Along similar lines, several of the interviewees noted that clinical pathway redesign currently takes place in every health system, and suggested that this should be done once, centrally, to avoid costly and time-consuming duplication. There was also an expressed wish for “a proper national discussion of best practice”, especially with learning from the vanguard sites to spread learning of what does and does not work in terms of new care models, again in order to streamline and focus efforts.

In the further interest of rationalisation, interviewees expressed the view that the merging of regulators and arm’s length bodies—e.g., NHS England and NHS Improvement—would be very helpful as it would simplify and streamline regulation, assurance, communication and “party lines.”

Capital and transformational funding was nearly universally flagged as an enabler, primarily to support the need for double running in the short term, and to enable the backfilling of clinicians’ time to free them up to lead service and pathway redesign.

A couple of interviewees articulated a clear view on the need for tailored support for clinical and lay chairs, as well as for clinical leads, and for lay members in general. Several interviewees said that all groups within their CCGs—the different Governing Body members, GPs leads and executive leads, as well as staff—would benefit from transition support, both to better understand the emerging new system, and to “find their place” in the new world.

This view was contrasted, however, by another:

“I think the best thing that NHS England could do to support us would be to give some serious thought to how best to support the development of the new skills and capabilities that we will need—primarily actuarial skills. They should absolutely not spend their budget on supporting CCGs now to simply do better, or on big support programmes for staff—we have to look to the future.” Paul Maubach, CEO, Dudley CCG

In terms of support from NHSCC, a consistent message was for the membership organisation to continue to be the voice of commissioners, able to take also

unpopular and difficult messages to the centre, without individual commissioners needing to stick their neck out. Several interviewees also held the view that NHSCC could play an important role in gathering, holding and sharing information about new developments and what works, with easy access to an evidence base, and coordinated sharing of learning and experiences:

“...it would be great to see some support for networks and exchanges of ideas. This could be through a package of some sort—ideally a mix of everything, i.e., both face to face and electronic support. And it would be very helpful to have an on-line repository of helpful documents, such as MoUs and partnership agreements so we could borrow from each other. NHSCC could be really helpful here—also by tracking and communicating what developments are happening elsewhere in the country, and how.” Janet Fitzgerald, Chief Officer, NEW Devon CCG

The future of commissioning

Virtually everyone interviewed believed that no matter what the shape of the future health and care system, some form of payor/commissioner/purchaser role would be required—not because legislation dictates it, but simply because there needs to be a body who holds the provider system to account, and provides oversight and challenge in the interest of patients and tax payers:

“You need a payor or commissioner for statutory reasons, but that is not the only reason—you absolutely need a body to hold the provider system to account—all the highest performing systems in the world have this function.” Paul Maubach, CEO Dudley CCG

Views then differed quite widely as to what this payor body or set of commissioning functions would, should and could look like, but there was near consensus that it would be a ‘thin’ or ‘strategic’ commissioner:

“Commissioning is just a collection of functions—maybe ‘commissioning’ will come out of the lexicon and we’ll instead talk about the functions...we’ll need a strategic commissioning function, including needs assessment, setting expected outcomes that would also make sense to the population, resource allocation, strategic procurement and holding the delivery system to account.” Janet Fitzgerald, Chief Officer of NEW Devon CCG,

There was an interesting split between those who took as a given that this strategic health commissioning function or functions should merge with local authorities to fully integrate health and social care commissioning, and to ensure alignment across the wider public sector, and those who felt quite strongly that such a merger would be entirely misguided. The latter group highlighted the politicized nature of local councils, and pointed to the lack of stability in some areas where neighbouring local authorities are governed by different political parties, and how notoriously difficult it then is to reach agreement on anything of real importance.

Succession planning in commissioning leadership

CCG leaders expressed a firm belief in the necessity of a payor, purchaser or commissioner in any future health system, yet an unexpected number of them were personally planning on retiring or changing career direction.

Interviewees were asked where they saw themselves in the next 3 to 5 years. Several CCG leaders spoke about retirement or a shift into a different area of work; many also spoke about the need of 'fresh blood' to move the change agenda forward. Out of the fourteen commissioning leaders interviewed, nearly a third said they were going to retire in the next 3-5 years. Others wanted to carry on with the general agenda of positive patient-centred change, but from a different position in the system, for example through becoming a local councillor, taking on leadership roles in the voluntary system or a national role at NHS England.

Summary analysis and conclusions

The picture that emerges from both the online survey and the interviews is of a commissioning landscape in transition, with the majority of commissioners playing an active and often leading role in large-scale change.

For CCGs involved in change and transformation, around four future landscapes have emerged that signal a possibly diverse set of corresponding end points—although one CCG can of course fit into more than one landscape:

- **CCGs operating across larger footprints:** those CCGs that are in formal collaborative arrangements with their neighbours, sometimes (but not always) on an STP-wide footprint for delivery. This includes CCGs with shared management teams, including the accountable officer; CCGs that are moving towards a formal merger with one or more neighbours; and CCGs who are gradually discharging a growing proportion of their statutory duties through close collaboration with neighbouring CCGs, eg through committees in common.
- **The integration of healthcare commissioning with local authorities:** CCGs which are moving towards much closer collaboration with local government and integration with social care, including pooled budgets, shared appointments and co-location of commissioning teams.
- **Developing an Accountable Care System:** CCGs which are working with their local providers to develop a viable prototype of accountable care, more loosely held together in a system model, than the related ACO. Like an ACO, though, the model includes a move away from Payments by Results as the metric of contractual agreement and towards a capitated and outcomes-based approach. Alongside the provider model, a 'strategic commissioner' function is being developed.

- **Developing an Accountable Care Organisation:** those CCGs that are working, sometimes as part of their local Vanguard, to set up a full-blown ACO.²

Common to the majority of commissioners, independently of what genotype they fall into, is:

- the belief in strategic commissioning as the obvious destination for current CCGs, and as a necessary component of any future health and care system.
- the strong belief in the value of clinical commissioning, and a solid wish to preserve and safeguard the clinical aspects of commissioning no matter what the future commissioning landscape might look like.
- the view that commissioning will need to take place at a number of different footprints, depending on services, patient flows, provider configuration and STP footprint.

The morale amongst commissioning leaders seems higher than might have been anticipated, with the vast majority simply getting on with the dual job of transforming the health and care system, and delivering safe affordable care today. However, there is also frustration about the perceived lack of clarity about the centre's policy position on e.g. ACOs, ACSs, and strategic commissioning. Arguably, the current policy landscape is unprecedented in its open-endedness and permissiveness. Some commissioners see this as the centre's way of encouraging disruptive innovation and local solutions to national problems. The flip side of this is a lack of clear direction and a sense of boundless options that can at best lead to every local area re-inventing the wheel; at worst, to CCGs taking on massive legal risk without being so aware.

There are lessons here for those in a position to help: much local effort and public resource could be saved by doing some things once, and once only. Foremost amongst them would be a set of clear definitions and parameters around what constitutes an ACO and an ACS, including the practical steps of a roadmap to get there. This should include guidance on options around how best to organise commissioning functions and activities in these new models, and clarity on what is and is not legally permissible. Such clarity and direction would save local systems time, money and effort, support risk mitigation, and help in raising the morale of those staff groups who suffer from excessive uncertainty about the future, both their own and that of the wider commissioning system.

In terms of national policy, at the top of commissioners' wish list is a streamlined, place-based regulatory framework and clarity on how new care models such as ACOs will be assured and regulated.

² In the wake of the steer of *Next Steps on the Five Year Forward View*, which was published after the conclusion of this research, more local systems are likely to focus on the development of an ACS than an ACO.

From the research emerged a lesson for those CCGs and their system partners who wish to develop a new care model, with associated changes to commissioning: you *must* start with the case for change—what are the population needs, and what are the specific local context and circumstances? Answering those questions will start to frame the options around a new commissioning and delivery model. By contrast, not starting at this end is likely to lead to an incoherent and thus unconvincing change narrative and a potentially considerable, misdirected use of capacity in the local system

Several success factors for large scale change emerged from the research. Some of them are external 'givens', such as a natural geography, and some are contingent on past deeds, such as having started the transformation journey early, and the absence of historic debt. These are largely outside the influence of today's actions. Others, however, are can be enabled, encouraged and developed, such as clinical and managerial leadership, including some specific leadership qualities, such as:

- having an open mind and a willingness to explore and embrace the unknown;
- resilience and a 'can do' attitude, coupled with a strong belief that seemingly conflicting views and demands can be resolved and overcome; and
- a single-minded focus on the prize coupled with an ability to engender and nurture trust and a culture of respect.

One can certainly argue that a leadership programme centred around these key qualities should form a critical part of any national development programme for commissioners. Such a national programme should arguably also focus resource on the capabilities currently in too short a supply:

- data gathering and analysis
- longitudinal analysis
- organisational development; and
- succession planning.

Further, in recognition of the fact that about half of all CCGs are likely to be currently seeking legal advice based on the findings of the survey conducted by NHSCC, and to avoid an excessive and wasteful spend on legal fees, the centre could sponsor 'legal surgeries' akin to the ones held in the run-up to CCG authorisation and in the roll-out of primary care co-commissioning. Whilst any statutory bodies would need to satisfy themselves that they are meeting their legal obligations, it seems likely that many of the questions raised about new care models are fairly generic, and, as such, they could successfully be answered in a legal surgery.

Another cost-effective and rapidly implementable intervention would be to organise and fund opportunities for CCGs to interact and share knowledge—electronically as well as face to face, e.g. in learning sets. This would answer to the 93% of survey respondents who reported they were trying to find out more about what other CCGs

do, in their preparations for taking forward new delivery and possibly commissioning arrangements.

Alternatively, recognising that development resource is often a zero-sum game, a different view would be to focus this instead partly or entirely on the future: what tomorrow's commissioners will need is partly determined by what commissioning activities and functions are deemed necessary and optimal to remain with a thin, 'strategic' commissioner. However, based on lessons from overseas, likely capabilities include actuarial skills, strong analytical and predictive modelling skills and the ability to comfortably manipulate and make use of big data.

Whether the focus is primarily on today's or tomorrow's commissioning needs, what is clear is that commissioners need whatever resource can be freed to support them to continue to deliver for patients and tax-payers alike.

Annex A-- List of interviewees

Professor Nick Harding, Chair, Sandwell and West Birmingham CCG

Jan Ledward, Chief Officer, Greater Preston and Chorley and South Ribble CCGs

Paul Maubach, CEO, Dudley CCG

Rakesh Marwaha, Chief Officer, Erewash CCG

Tim Goodson, Chief Officer, Dorset CCG

Mary Hutton, Chief Officer, Gloucestershire CCG, and STP lead

Dr Alistair Blair, Chair, Northumberland CCG

Janet Fitzgerald, Chief Officer, NEW Devon CCG

Dr Iain Chorlton, Chair, Kernow CCG

David Smith, CO, Oxfordshire CCG, and STP lead

Amanda Bloor, Chief Officer, Harrogate and Rural District CCG

Dr Andy Whitfield, Chair, North East Hampshire and Farnham CCG

Dr Brendan Hudson, Chair, Sutton CCG

Dr Ranjit Gill, CCO, Stockport CCG