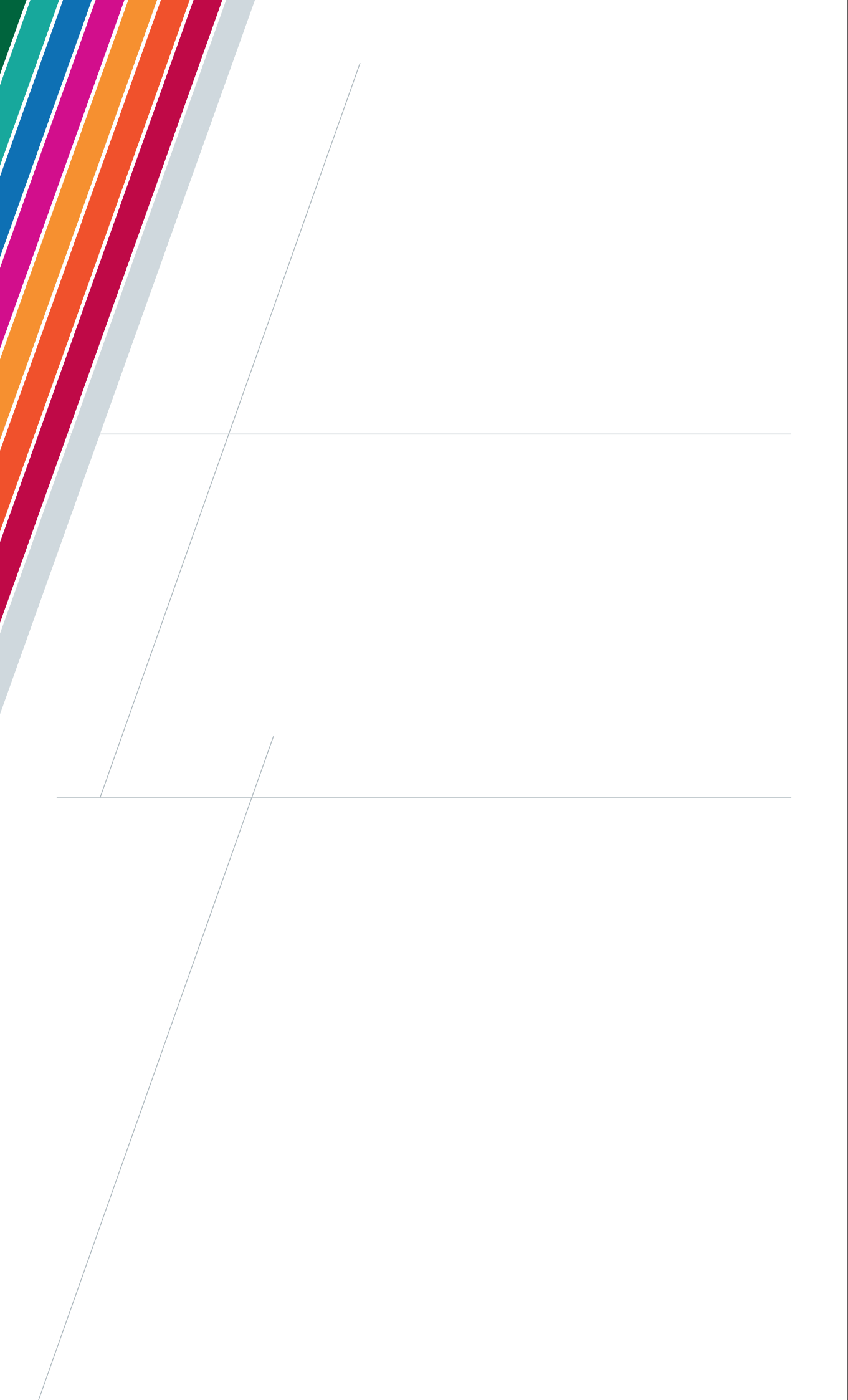




WHERE NEXT FOR COMMISSIONING?

JUNE 2017



Welcome to the first in a new publication series from NHS Providers in which we will be promoting the views of leaders from NHS foundation trusts and trusts, as well as those from other parts of the service, on some of the key issues facing the NHS today.



Each publication in our *Provider voices* series will consist of interviews with a select group of leaders to draw out the key themes for debate. We hope this will make a valuable contribution to discussions on how the health service can respond to the challenges ahead.

Our first topic is *Where next for commissioning?* which, in our view, is rarely at the forefront of debate. That needs to change. As the NHS moves to collaborative local system working via sustainability and transformation partnerships and accountable care organisations and systems, we need a full and proper debate about how commissioning (and provision) needs to adapt to this new, emerging, world.

There are a range of important questions to discuss: should the purchaser-provider split survive? As we move to strategically plan on larger footprints, is the current landscape of more than 200 clinical commissioning groups still the right one or is more consolidation needed? How do we ensure commissioning becomes more strategic and focused on improving whole population outcomes as opposed to tactical, low value, high friction cost, contract oversight? How do we integrate health and care commissioning? And should we be trying to divert more resource away from commissioning to frontline patient care?

It's great to have eight different sets of answers to these questions from a range of perspectives. We are grateful to the leaders who took the time to contribute to this publication. And we are grateful to Andy Cowper for carrying out the interviews.

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Chief Executive, NHS Providers

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KATHERINE SHEERIN
Chief Officer
NHS LIVERPOOL CLINICAL
COMMISSIONING GROUP



Commissioning should, in theory, be a key driver of high-quality public services in the 21st century. However, in healthcare, commissioning is sometimes perceived as the 'dog that doesn't bark'. For example, the *Five year forward view*, which set out the NHS' future strategic direction of travel from 2015 onwards, was largely silent on the role of commissioning.

After 25 years, it feels like the concept of commissioning in the NHS is at a crossroads. Questions over its effectiveness, structure and value for money abound, as do questions about the effectiveness of the internal market. Sustainability and transformation partnerships (STPs, née plans), new care models and accountable care organisations and systems all challenge the concept of a separate commissioning structure and the long standing 'purchaser-provider split'.

It therefore felt like a good time to ask trust leaders and a small selection of those involved in commissioning for their views on commissioning's future and how it needs to change to deliver better health outcomes.

In the interviews that follow we hear from all the different parts of the provider sector – acute, mental health, community and ambulance trusts – as well as from local government, local commissioning and the voluntary sector. The backgrounds of our interviewees – appointed chairs, commissioners, providers, life-long NHS professionals, elected councillors and charity experts – means that we have a range of different perspectives to consider. Some clear themes emerge.

Before exploring these themes, it is worth briefly reminding ourselves of both the definition and history of commissioning in an NHS context.

So what is commissioning anyway?

Healthcare commissioning is, by definition, a somewhat amorphous concept. Unlike direct healthcare provision, it isn't a physical service, closely associated to a local building with clinicians delivering and patients receiving something tangible and concrete. It's therefore not surprising that NHS commissioning has never really entered the public's psyche. However, the decisions commissioners make are of huge strategic and practical importance.

There is no single definition of NHS commissioning. The Department of Health adopts the following definition: "[Commissioning is] The process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers."

On its website, NHS England goes into more detail: "At its simplest, commissioning is the process of planning, agreeing and monitoring services. However, securing services is much more complicated than



securing goods and the diversity and intricacy of the services delivered by the NHS is unparalleled.

“Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically-based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

“There is no single geography across which all services should be commissioned: some local services can be designed and secured for a population of a few thousand, while for rare disorders, services need to be considered and secured nationally.”

This definition helpfully stresses the fact that commissioning must take place across different footprints – on a local and national footprint and points in between. We therefore need to be careful about making too broad a set of assumptions about 'commissioning'.

The NHS England definition also points to the wide range of activity that can result from a broad conception of commissioning. These activities can range from assessing and defining population health needs right the way through to detailed contract oversight. It is here that we encounter our first difference in perspective – where the main focus on that range of potential commissioning activity should lie.

As the provider interviews in this report show, what provider organisations want from commissioning is a strategic planning approach that focuses on health outcomes and meeting population health needs at scale. They worry that commissioning in the NHS has defaulted to low-value, high-cost, tactical contract management, procurement and tendering. This approach also risks missing the intention and value of strategic commissioning – planning to improve health outcomes at a whole population level.



After 25 years, it feels like the concept of commissioning in the NHS is at a crossroads.

Commissioning in healthcare – a potted history

Healthcare commissioning emerged 25 years ago when, in 1992, the Conservative government introduced the purchaser-provider split creating a so-called 'internal market' in the NHS.

Between 1997 and 2010, the Labour administration entrenched this split, creating 150 primary care trusts (PCTs) that received 80% of NHS funding for hospital, mental health, community and GP services. This meant commissioning had considerable financial clout. In 2009 the 'split' was consolidated when PCTs divested themselves of their community services. Local commissioners were responsible for commissioning



a wide sweep of services, and stood alongside a smaller centralised commissioning function responsible for primary and specialised care.

However, perhaps the biggest shake up in commissioning's history has been the introduction of the Health and Social Care Act in 2012. This saw a focus on commissioning, competition and choice as the three key drivers for NHS reform and improvement. In particular, the 2012 Act established the NHS Commissioning Board, now known as NHS England, as a new central body which would operate at arm's length from politicians and the Department of Health.

PCTs were abolished and local commissioning was placed in the hands of 211 clinical commissioning groups (CCGs), governed by local clinicians. Health and wellbeing boards were also established to bridge the divide between health and social care and to encourage integration between local authorities commissioning social care and local NHS service commissioners and providers.

As well as overseeing local commissioners, NHS England is also directly responsible for the commissioning of specialised services (what are known as tier four services). With an annual budget of £15.6bn, specialised commissioning seeks to ensure that highly specialised services are provided across population groups that usually number more than one million – so usually on a national, regional or sub-regional basis – with the aim of ensuring equitable access for all patients and service users. The kind of services that fit under the heading 'specialised' range from renal dialysis and secure inpatient mental health services, through to treatment for rare cancers and life threatening genetic disorders.

We do not explore specialised commissioning in this report. However, it must be acknowledged that this also has an important role to play in and impact on the types of services that trusts can provide, an impact on the relationships between commissioners and providers, locally and nationally, and an impact on the strategic nature and efficacy of commissioning overall.

The themes

Although the views on commissioning expressed in the interviews are diverse, five key interlinked and overlapping themes emerge:

- the value of commissioning getting closer to people...
- ...and understanding local place: the importance of scale and geography
- the need to accept the emerging diversity of approach to commissioning structures
- the rapid blurring of the purchaser-provider split and a lesser focus on the internal market
- the need to focus on commissioning as a strategic function.



Getting closer to people...

The first strong theme coming through the interviews is the importance of putting the patient first, and making the case for service improvement through better commissioning and 'co-production' with patients and the public. Commissioning should be seen as a way to understand individual and population needs and incorporate them into the design and delivery of services.

Anthony Marsh, chief executive of West Midlands Ambulance Service NHS Foundation Trust, rightly exhorts us not to lose sight of patients in our structures: *"We must always put the patient at the front of what we do, and work backwards. It does seem that ... we have lost sight of the aim to improve care for patients and to support our workforce to be the very best they can."*

And Cllr Izzi Seccombe highlights what she sees as the difference between local government and NHS commissioning: *"...a local authority commissions services to support the person to achieve their goals. The NHS still often commissions for a certain number of units of treatment, rather than using a person-centred approach."*

Jeremy Hughes, chief executive of the Alzheimer's Society, advocates strengthening the link with patients: *"Among the biggest opportunities facing the NHS is the opportunity to make the connection between providers and patients stronger."* He goes on to stress the need for balance, too, between the 'N' in the NHS and local commissioning which *"should be about empowerment and planning"*.

And West London Mental Health NHS Trust chief executive Carolyn Regan is also clear on the value of commissioning as it evolves: *"...there is a big element of co-production, with patients engaged in strategic planning, recruitment of staff, service redesign and evaluation."*

...and understanding places: the importance of geography and scale

This focus on people and patients underlines the importance of place in the provision of public services in general, and for health and social care in particular. Although not clear from their name, STPs are essentially about place, and place-based systems of care. Modelled on a set of defined geographical footprints, they exist to deliver better integrated health and care services to their population more efficiently and effectively, thereby better meeting patient needs. The scale on which STPs operate is now starting to change the shape of commissioners, providers and local government and how they inter-relate.

Geography and scale

Katherine Sheerin, chief officer, NHS Liverpool Clinical Commissioning Group highlights the need to balance operational economy of scale with local engagement, as the shape of providers changes around them: *"CCG size and configuration are issues ... As providers coalesce, chains of providers develop or as more integrated provision emerges, the system can't have a plethora of small commissioners trying to solve ever bigger problems. However, we mustn't lose local intelligence and engagement. It's about what works..."*

Scale of operation is high on the list of provider concerns too. As Nick Moberly, chief executive of King's College NHS Foundation Trust, puts it: *"...one important issue linked to all of these emerging changes is that of scale. Increasingly, as STPs take hold and sub-regional planning takes place, we have to ask whether CCGs are operating across too small a geography."*

The geography and sense of place is where NHS commissioning and local government have a meeting of minds, according to Cllr Izzi Seccombe: *"We have found many shared values. CCG commissioners have a clear sense of place, and of the patient as a whole person with assets beyond their health challenges."*

Integration

Most interviewees focus on integration, in its many different guises, as being fundamental. For example, David Evans, chief executive of Northumbria Healthcare NHS Foundation Trust, argues that the imperative is to overcome the divisions and create a joined-up delivery system: *"I believe we have to change. The current system cannot deliver ... the divisions between primary, secondary and tertiary care used to seem straightforward. A [single] system for managing, commissioning and funding pathways must help."*

Cllr Izzi Seccombe is looking to the opportunity of STPs: *"STPs need to be an inclusive partnership to improve population health and services. If they are not, then the chances of them achieving their objectives are slim ... There is real potential for STPs to reshape services for the benefit of their local communities, but they need to be genuine partnerships between health, local government and the community and voluntary sector."*

Diversity of approach and experience

Our interviewees recognised and welcomed the diversity of approaches now opening up for commissioners and providers across the country. There is also great potential for local partners to lead and shape bespoke arrangements that better meet local needs through STPs, new care models or devolution deals.

As Anthony Marsh commented: *"...[the diversity of approach] need be no problem if there is an absolutely clear direction of travel within the Five year forward view."* Or as Carolyn Regan pragmatically puts it: *"Let's welcome*



diversity in delivery and organisational forms that meet local situations shaped by local players, including patients, carers, residents, better. We know one size does not fit all, and we know there are some issues with commissioning, geographical or care model boundaries."

Interestingly, contributors were keen to ensure that, as a sector, we learn from the past and do not welcome new approaches just for the sake of it. We should not see STPs as "a shiny new project" as Jeremy Hughes put it, or yet another layer of bureaucracy, which was Anthony Marsh's warning. We must adapt the system to accommodate STPs fully, and that includes adapting commissioning. There would be little point in just adding STPs as another layer in an already crowded, diffuse and confusing system structure, though we must fully and properly work through the required changes.



We are seeing rapid shifts in the previously rigid boundary between commissioners and providers.

Equally telling was a recurrent focus on learning from recent initiatives in commissioning, which, however well intentioned, had not delivered. While many contributors to our report commended efforts to move to outcome-based commissioning, for example, they frequently cited the need to learn from the experience of the Cambridgeshire older people's contract and from recent NHS111 procurements.

Carolyn Regan rightly emphasised the important of diversity in experience and encouraged "*staff [to gain] experience of commissioning and providing ... we need a blend of experience that understands both sides of the table.*"

Purchaser-provider split – does it really matter?

When done well, commissioning performs a key, strategic, function. However, many interviewees queried whether the purchaser-provider split had actually had its day, what contribution it now made and, by extension, whether the existing structures in health and care are fit for purpose. These questions have become particularly important and relevant given the new national policy focus on place-based collaboration, exemplified by STPs and the move to accountable care models.

We are beginning to see large and rapid shifts in the previously rigid boundary between commissioners and providers, and whether or not that boundary should remain (or even matters) is a live question.

Nick Moberly's view is clear: "*I certainly see a blurring of the traditional roles of commissioner and provider ahead. Historically commissioners have bought specified units of service ... Increasingly they will be analysing their populations, stratifying according to risk and setting outcomes-based measures ... allocating providers block sums to deliver those outcomes.*"

This perspective accords with David Evans' view that the logical solution is the move in some parts of the country, including his own, to greater collaboration via an accountable care organisation or system.

Carolyn Regan similarly welcomed recent developments which saw *"the blurring of payer and provider roles and responsibilities."* Jeremy Hughes favoured retaining the split but still advocated for *"payers and providers to get better at talking together ... and to look at changing care across the whole of England rather than in individual, institutional silos."*

However, dismantling these boundaries does come with risks and conflicts that will need careful management. Nick Moberly believes that shifting to accountable care-type structures will alter the balance of risk: the model of moving to block payments in return for outcomes *"...means effectively seeking to transfer a great deal of risk to providers."*

However, Cllr Izzi Seccombe believes that the way health separates commissioning and provision institutionally, as well as functionally, may be over-done. For her: *"Local government's clear distinction between commissioning and provision means we don't necessarily see it as an insuperable conflict of interest if both are located in one organisation."*

Commissioning as a strategic function

What is clear – both implicitly and explicitly from our interviewees – is the need to elevate commissioning to focus on the strategic and ensure it delivers as much value as possible. We need to shift our perspective upwards and outwards. We need to embrace longer term, population-level issues, rather than focusing on the more 'insular' issues of tenders, procurement and contracts. Our current fixation seems to be micro not macro; tactical not strategic.

Cllr Izzi Seccombe argues for the local government approach to commissioning: *"Ultimately there is useful learning for the NHS from local government's approach to commissioning. It is about so much more than contracting and purchasing, and when seen in this light, the role and value of commissioning can be truly appreciated."*

Against a backdrop of rising demand and severe financial constraint, the need for commissioning to be streamlined and effective is more important than ever. The commissioning infrastructure was built up in a time of plenty – the 2000's – when there was money to spend. Now, we need to ask whether we are allocating too much scarce resource on functions which are not directly patient facing.

Should more of the commissioning pot be spent on delivery? Anthony Marsh asks the question: *"We need to think about whether, given the substantial cost of commissioning, it really provides value for this investment. How does commissioning improve and add value?"*



Whatever happens in the future, and whatever the structure, our interviewees broadly agree that there will always need to be some form of commissioning function. As both Katherine Sheerin and Nick Moberly, respectively, sum it up:

"Some of what we do now may happen more in the provider sector in future, for example service redesign, but we will still need strategic oversight and a way of holding the system to account."

"There will continue to be a role for a party in any health system to understand population health needs, determine outcomes and allocate funds."

Where next?

The themes that emerge from the interviews are enduring and should form the basis of conversation at every level – local, regional, national – about how we create the strategic commissioning function that all our interviewees feel we need.


Fundamentally we must ensure that we:

- focus on the magic formula of balancing economy of scale with patient involvement and clinician engagement
- recognise and respect the diversity of approaches that are now emerging. Variation can be seen as a negative but diversity must be embraced. What works in Wigan will not necessarily work in Winchester
- derive maximum value from our commissioning structure, mindful that we should maximise the resource devoted to patient-facing care
- learn from other sectors including, but not exclusively, local government, with its different, longer and, perhaps, more strategic experience of commissioning
- rule nothing out. Our next steps should be an enabling framework: a direction of travel rather than a set of prescriptive directions
- finally, set our sights on creating a strategic commissioning function that considers the needs of the population and then strategically plans to meet them within the available resources.



We need to elevate commissioning to focus on the strategic and ensure it delivers as much value as possible.

The next five years will be as challenging as the last. Commissioning is central. We do not need arguments about whether or not commissioners should be scrapped or whether the purchaser-provider split is dead. We need to fast forward to 2022, to work out what we want to have achieved for our populations by then, and identify the new approach to strategic commissioning that will help us do that.



Thanks to Andy Cowper who carried out the interviews in this report, many have been updated since to take into account more recent developments in commissioning. Thanks also to Miriam Deakin for her invaluable contribution.

THE INTERVIEWS



DAVID EVANS

Chief Executive
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST



David became chief executive in November 2015, having been the trust's medical director and a practicing consultant obstetrician. Previously he was clinical director for obstetrics and gynaecology. He has also been the trust's Caldicott guardian and the lead for risk management for a number of years. In addition, David is an assessor for the National Clinical Assessment Authority.

My honest opinion is that the purchaser-provider split has outlived its usefulness. The NHS environment has changed hugely from the time when commissioning seemed like a good idea. Back then, there was plenty of money in the system, and options for getting better deals for your money by managing the market.

Now money is tight, the question must be whether money spent on commissioning wouldn't be better used delivering services. Look at the situation nationally: some providers are in dire financial straits and their commissioners sit on surpluses. In other places, the reverse applies.

We have seen private providers hit this wall too, as well as some high-profile commissioning decisions (as in Cambridgeshire) that fall foul of the reality of providing services.

The value of accountable care organisations

Moving to something like accountable care organisations (ACOs) must be worth a try, as a way of making best use of the money in the system.

If many people in the NHS look up what an ACO is in the USA context, they will probably find it scary. Some American ACOs are, frankly, aggressive money-making institutions. We have aligned ourselves with Ribera Salud Grupo in Valencia. We like their concept of a truly integrated service out of hospital, run by a joined-up delivery system: that is where we want to be.

Since September 2011, we have managed the adult social care contract for Northumberland County Council so we are a step or two ahead of the integration game, and of letting the financial systems support it.

So we have adopted and adapted a model from Europe, which we think aligns systems and ways of working. Our health economy has a long history of joint working and a stable, sensible and grown-up set of financials which can only support this system, especially when the overall NHS financial package is as tight as it can be.

Sustainability and transformation partnerships

Our sustainability and transformation partnership (STP) footprint is so large that we are in with the rest of the north-east of England. We are confident that our system is good and functioning, but to get all the rest to follow our model would be a big ask. As with all STP footprints, the changes are going to be challenging.

STPs seem like a broad-brush effort to get people to sit up and think and be in the same room working together – which some organisations have never done, so that will be good. The idea that they can deliver quickly may need revisiting – our clinical change in Northumbria took years and



years. Many service changes need consultation and political sign-up, which take time.

There are some quick fixes and things that should have been fixed years ago. Taking a mid- to long-term view, it is good for organisations to sit down together and get their homework marked, but there is a lot of work to do.

The scope and scale of the changes proposed is enormous: Sir Bruce Keogh, shortly after his appointment, suggested the NHS has never had an honest conversation with the British public about what it can deliver, and I think that point still stands. Treating long-term conditions better is the real challenge – the NHS is facing a bow-wave of demand and demographics.

Service transformation takes longer than you think

Our ACO concept was part of the primary and acute care systems (PACS) vanguard, but the pace was meant to be slower. We planned to implement in year five; now we are being asked to implement it in year three. All involved here were comfortable with the longer timescale.

In my experience, major service change takes between 5 and 15 years. Our provider A&E reconfiguration took 15 years, 6 years' thinking and 9 years' planning to achieve what we did – then there was the political stuff, the planning, legals, buying land, building, training. You don't just flip a switch.

Looking at what is happening to clinical commissioning groups, they are in a very hard position. Some are doing great, declaring big surpluses, but then you look at their providers in deficit, and you think 'with one pot of money – is that success?' There has been a big shift of risk onto providers. You see glimmers of hope with personal health and education budgets, illuminating how the shape of healthcare delivery will differ.

The devolution agenda has become a bit uncertain. The proposed north-east devo deal has been called off, so we are watching 'devo-Manc' with interest.

To me, the real deal is about moving to the Riberia Salud-type ACO model. A few years ago, everyone was talking about the Geisinger and Kaiser Permanente models, Northumbria and Torbay colleagues first met on [The King's Fund chief executive] Chris Ham's ACO group US tour. Those US ACOs have a joined-up, integrated

system working in a very different marketplace, but they are very profit-driven (and they do deliver some fantastic services). We have dipped into a range of ACO-type systems around the world: the Riberia Salud model looks like it could work in the NHS.



My honest opinion is that the purchaser-provider split has outlived its usefulness.

Thinking about how in future, nationally-commissioned, specialised services will interact with local commissioning, it wouldn't hugely affect our model. We have long had a 'hub and spoke' arrangement with Newcastle for specialised services, and that has worked for both parties.

Co-commissioning for primary care

Then there is the question of how co-commissioning for primary care fits with an ACO model. We are getting legal advice, but it seems that CCGs will keep a small strategic commissioning role based in the local authority, and the rest becomes part of the ACO. From being a PACS vanguard, we have seen that joint work around integrating primary and secondary care can deliver real improvements. Will it enable us to remove money, though? We will see.

If it is really about making the best use of what resources we have, I think this offers an opportunity. It is also an opportunity to let specialist staff, traditionally based in hospitals, work in communities, especially clinical pharmacists – who are fantastic on medication reviews in care homes, and on chronic disease management in primary care. So, there are obviously good clinical moves to be made.

The traditional business model of primary care makes it very hard for practices to employ expertise without being part of something bigger. Given our serious shortfall of GPs, different models of staffing primary care must be part of the future. The acute sector's specialist practitioners and nurses could offer as-yet unrealised potential for primary care.

Training a GP takes a decade. It takes one to three years to train a pharmacist up from a master of pharmacy to independent prescribing. We have had pharmacists integrated as part of frontline teams for a long time, and on medicines management in care homes and GP practices. This is vital to building the alternative workforce, and secondary care has been expanding pharmacists' roles for a long time. Now there is an opportunity for primary care to do this in making a more joined-up system: the economics become easier.

Personal budgets

I haven't seen the personalised budgets concept explored to its full potential. We have some knowledge from other sectors: education and long-term handicap: and it has worked well where it has worked well, but I have not seen proper evaluation. It is a concept the NHS is yet to fully explore, but it is interesting.

Another interesting concept is outcomes-based commissioning. Cambridgeshire has obviously had a big problem with trying it, but in theory, it should be workable around data, agreeable risk sharing and standards, if we can make it work and if it is better for patients, why not?



The need for reform

I believe we have to change. The current system cannot deliver what is needed to support our population in the future even if funding was unlimited. The divisions between primary, secondary and tertiary care used to seem straightforward but I think will not deliver for the future. A system for managing, commissioning and funding pathways must help.

Our reactive system of a National Sickness Service, rather than a truly anticipatory health service, has to change. It is obviously good that more people are living for longer, but with complex conditions, community-based support and avoidance of acute admission must be the goal. Hospitals need to change from being refuges for acute illness to centres of expertise supporting community-based services to safely manage individuals in their home to avoid the need for acute episodic care.



Our reactive system of a National Sickness Service, rather than a truly anticipatory health service, has to change.



MARIE GABRIEL

Chair
EAST LONDON NHS FOUNDATION TRUST



With over 14 years of NHS board experience, Marie is currently the chairperson of East London NHS Foundation Trust (ELFT), an 'outstanding' provider of mental health and community health services in London, Bedfordshire and Luton. Recognised nationally for staff engagement, internationally for quality improvement, ELFT is working with NHS Improvement and The King's Fund to support inclusive cultures. A member of the workforce race equality standard advisory group and chair of the London mental health trust chairs group, Marie's contribution was recognised through her incorporation on the inaugural HSJ Inspirational Women list.

We work with multiple commissioners and across the mental health and community sectors. We benefit from having two big sustainability and transformations partnerships (STPs) in north east London and Bedfordshire, Luton and Milton Keynes where we can achieve best value for money and highest quality for our local communities.

It's also interesting to have different commissioning climates and styles, so we can then say 'we do this over there and it works and helps us.' We also have collaborative system arrangements in two parts of our trust – so we can work system-wide, but keep our local focus.

The contrasting challenge is that we sometimes end up going through the same process several times. It varies depending on external pressures and what's happening in the relevant local authority.

We are also specialist commissioning providers for NHS England, and that gives us opportunities to influence national policy slightly. And our local authorities are also our commissioners.

STPs

STPs are a new challenge: how can we work effectively with boroughs and health providers and commissioners to improve? They imply much more commissioning in partnership in collaborative ways, rather than via the tender process.

Another challenge arises because we deliver a financial surplus. Increasingly, people say 'you've delivered a surplus so you clearly don't need more money for services'. McKinsey analysis said this is because we are productive, hence we are not in the red. Finance is a challenge for the whole system: the rest of the system locally is in deficit, and we are not but we readily recognise our responsibility to support the system to be in balance and equally importantly to develop truly integrated care.

There is quite a variation in commissioning styles with some narrowly contracting as opposed to commissioning which is a process about the whole cycle. It would be better to have relationships where commissioning was five-yearly, as opposed to annual and recognised system challenges. Commissioning support units (CSUs) also need to be able to provide the support and information that the clinical commissioning groups (CCGs) need as we move towards outcome-based and system-wide arrangements.

There is much discussion of the relationship between local and national commissioning. As more responsibilities get devolved to local commissioning, we as a provider would like to understand more about how that transition will work, and the role of CSUs in that.



Then public health commissioning sits in local authorities: understandably, their priorities can differ from CCGs', and we have to get used to that difference. To be really radical, let's look at where commissioning fits, and social care being an essential element of what we do. Have we got the right fit? This issue keeps on raising its head: how can health and social care commissioners and providers collectively work together, with current funding and structural challenges?

The need to avoid acute sector dominance

The STP process needs to align overarching priorities to make sure it is not entirely focused on the acute sector and the financial challenges many providers face. We have expertise as an out-of-hospital provider and there must be just as much focus there.

To tackle health inequalities, STPs need a broader group around the table, including the voluntary sector.

It's too early to tell whether STPs can help support more joint commissioning (or at least alignment) between primary care, social care, public health and secondary care. And it depends which STP you mean. We're involved in two. In one, there is an accountable care organisation-type vanguard, which brings a different flavour to how organisations work together. This is on a more sub-STP-wide footprint – addressing a big financial problem. In our other STP, the option to close the financial gap is more workable.

The importance of place-based care

The development of new care models is not, for us, that much different to our work transforming services in east London. It's all about place-based care, and about existing local relationships at sub-regional levels. Sometimes it can be quite hard, as local authorities or other health colleagues may see relationships differently to us. What we believe is that the emerging NHS system requires a new type of leadership.

Local authorities' drivers are different. We have four mayors across our east London patch and four local authority leaders in Bedfordshire and Luton, and it is different working with each individual. Ultimately, it is about successful joint working across the health and care systems, and politicians do have an important impact on that joint work.

Local authorities have to think about services for the whole community: parks, roads, rubbish, libraries. These are all key parts of determinants of health. They think about everybody, not just about needs for health conditions.

The challenges facing CCGs as currently configured are hugely variable by CCG. There is even variation within CCGs and, like boroughs, they are all different and have differing priorities.

Avoid structural reform unless it is needed

CCGs have varying maturity profiles. We believe that we should not fiddle with CCGs unless there are real problems. CCGs may work better together, and there is a clear move for them to do so. When there are good relationships locally, CCGs work well together.

We are unsure how nationally-commissioned, specialised services will interact with local commissioning in future – there does seem to be a move to push STP systems and as part of devolution we may be moving to a specialised commissioning board for London.

Some of this remains unspecified. Think about forensics: you can't have really local relationships. It has to be done on a larger footprint. The connection needs to happen when someone leads on a geographical footprint. That involves transition, and part of our job is to put services and support in place to help make patients part of the community.

We have heard that, for example, if a commissioner wants to buy mental health services for the whole of north-east London from the relevant trusts, they will say they currently get different outcomes and deals per provider, so we start talking about better standardised quality pathways or joint work as possible ways forward.

Payment reform

It's all developmental. We were told last year that the centre was thinking about changing the tariff, and so we couldn't progress on a local mental health tariff as it was all going to change. But then it didn't. Trusts need to be nimble and fleet of foot to manage this uncertainty and keep their focus on the patient.

The ongoing talk about 'granulising' tariff – we've been looking at capitated budgets and the different possibilities there. We've also been party to national discussions on tariff and whether it's an obstacle to the new world. We are not keen to go back to block contracts, but outcome-based commissioning means we'd need much more analytical capacity, business intelligence and agreed outcome measures. Fees for service is good when you want more of the service; less good when there's less money and more demand.

Co-commissioning for primary and specialised care

In terms of co-commissioning both for primary and specialised care, we know that co-commissioning in primary care makes sense as it brings a greater sense of ownership. It works well, for example in Tower Hamlets and our expectation is that this will spread across our STP areas in some form.

For specialised commissioning, it may be an issue of having providers work out among themselves how to manage across the whole system



(in an anti-competitive way, of course). We are having those discussions on medium secure mental health services across north and south London and looking at wider collaboration across north central and east London. If confirmed, this means we would be responsible for all patients including those in the private sector, i.e. to oversee best value for money and recovery.

A more personalised approach

Discussions about a more personalised service, and the concept of personalised budgets, has had very little impact so far. We could be interested. Local authorities use personal budgets, but still restrict what service users can access through those budgets. GP colleagues do much more of this: some support it, some do not. That agenda has yet to get far in mental health.

By contrast, we have been very involved in capitation budget work in Tower Hamlets and other parts of east London. We also have some shadow outcome-based alliance contracts in Hackney, but these are still being tested so success is yet to be seen.

The future of the purchaser-provider split

We're gradually moving away from the purchaser-provider split as traditionally understood, recognising that it may not allow shared accountability on the whole care pathway. Although it's very helpful to know which services you deliver and are accountable for, surely it is best if all players in the system know their role is delivered through collaboration (which does not mean merger). That's what devolution and vanguards should be about: providers working together to interact and wrap the right care round the patient.

Commissioners may struggle with parts of this – and CCGs may often have their primary care provider heads on. We have to be more innovative. That's not just about acute providers running everything: there has to be a more equitable process, to move care closer to home on the patient care pathway, and mental health has already made extensive and successful headway with that shift.

In our view the best NHS leaders will be those who understand complex systems, can bring the anxious and worried together to achieve a common purpose and are willing to take personal risk. They need to be authentic and to believe in doing the right thing for the communities they serve. We hope the NHS system supports that type of leadership from whichever sector to make STPs and other collaborative arrangements a success.



The best NHS leaders will be those who understand complex systems, can bring the anxious and worried together to achieve a common purpose and are willing to take personal risk.

JEREMY HUGHES

Chief Executive
ALZHEIMER'S SOCIETY

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Jeremy joined Alzheimer's Society in November 2010. He is leading the charity in its five-year strategy, 'Delivering on Dementia 2012-17'; managing an annual budget in excess of £90m. Jeremy co-chairs the Dementia Friendly Communities Champions Group with top broadcaster Angela Rippon for prime minister Theresa May. Jeremy was previously chief executive of Breakthrough Breast Cancer. Before that he was head of external affairs at the International Federation of Red Cross and Red Crescent Societies. His career in health and social care charities includes leadership posts at the British Red Cross, Leonard Cheshire, Muscular Dystrophy and NCH Action for Children.

Among the biggest opportunities facing the NHS is the opportunity to make the connection between providers and patients stronger. With the NHS under financial strain, providers are forced to chase incentives to balance budgets rather than enhance care for patients. To me, and to patient organisations, it is evident that commissioners need to address this imbalance.

Sustainability and transformation partnerships

The sustainability and transformation partnership (STP) process aims to help align commissioner and provider plans across a larger footprint. That begs two thoughts on STPs.

Firstly, we seem to invent new approaches to commissioner reform – we've gone from the Better Care Fund to vanguards to STPs in a couple of years. The system seems to jettison the last project and replace it with a shiny new one, making it hard to keep up from outside the NHS and to see the opportunities.

The second is whether STPs can deal with the regional and local variation across the health system. Do markedly different plans need to be drawn up independently across different landscapes? The need for good Alzheimer's services is pretty similar in Bangor in Northern Ireland, in Bangor in Wales and in Bognor Regis in England.

Within the English NHS, are the differences in care provision so great as to need us to draw up different STPs for every footprint? And what happens if you live on a boundary between STP footprints: a real challenge.

I live in north Dorset, and many of our local health services are provided from south Somerset. But these are two distinct STP footprints. Local commissioning should be about empowerment and planning: clearly that is great, but we must always remember the N in NHS. This is about a national service and support. Our dementia helpline often gets calls from people who say 'my parent has dementia in another part of the country, and I have been told they should have this and that service, but where they live they can't get them.'

Clearly, the NHS faces difficult decisions but uneven access to dementia care is unhelpful because it leads to higher and more costly health needs. It is particularly unhelpful to have a postcode lottery in this.

Another possibility is that STP plans represent an attempt to drive joint commissioning at a rational scale. Money talks: if STPs pool budgets and re-address where money is spent across a health economy, then we could be onto a winner and see better allocation across the sectors within health and care. Without that real influence over budget, and particularly without full participation of local government, the risk is that STPs



become like health and wellbeing boards – all too often talking shops, without much result or impact.

However, it is also important to remember that in social care, most people get no state funding at all. Integrated budgets are potentially better used for state-funded services, but we should be concerned about tens of thousands of people paying £1,000 a week on their own care provision. The people facing crippling care costs should not remain outside of the STP programmes' thoughts, but this may well be the reality.

Engaging patients and the public

Another very significant element – engagement of patients and the public – is still often pretty rudimentary. Understanding of what we are trying to change in devo deals, and health and care reform overall, by the public and patients is still often very poor.

Most people don't understand that the NHS doesn't fund social care until they know someone hit by a crisis of need. Unless we involve public opinion and understand more fully, we'll come to the crunch of closing or downsizing the beloved local hospital to meet a public and local MP outcry as the changes have not been explained properly. And so we go back to square one.

Clinical commissioning groups (CCGs) face two very significant challenges: one is their ability to be informed by consumers. Patients matter. I chair a CCG improvement/assessment group on dementia, and it is very clear we don't collect data well enough to inform CCGs on patient experience. The friends and family test is lightweight and not useful for dementia.

This can be much better: we know the biggest demand comes from patients with long-term conditions. Most CCGs spend on dementia was over £260m in the last year, but our information on falls, time spent in acute settings and emergency readmissions for dementia shows that evidence-based commissioning is not supported well. It is also of concern that information about patient experience doesn't seem to be built in to support provider behaviour change by CCGs.

The second major issue is about being able to share experiences across and between CCGs. Within CCGs we see some great examples of very good practice, but it is not consistent. What is each CCG doing to spread their good practice across the whole of their patch? Most have a dementia lead, but how well supported and resourced are these people to share learning and best practice across their area? Equally, we need inter-learning between CCGs to avoid silos of bad or outdated practice.



Clearly, the NHS faces difficult decisions but uneven access to dementia care is unhelpful because it leads to higher and more costly health needs.



Co-commissioning for primary and specialised care

In terms of co-commissioning both for primary and specialised care, personal health budgets and integrated personal commissioning give us an opportunity to do bottom-up working with patients and their advocates to use resources better. The All-Party Parliamentary Group on dementia found people attending 20 different agencies to get the support they need, especially patients with other co-morbidities.

We are not getting integrated care in a system driven by top-down specialism. Pilots we have done in Nottinghamshire on personal health budgets and personal commissioning to put choice in the hands of patients, with support from organisations like ours, can provide much more joined-up and helpful ways of using resources.

The move towards outcomes-based commissioning is likely to be difficult for many, but must be the way forward. It is about better data on patient experience and satisfaction: because we don't know what they expect, it is hard to define outcomes and quality for them. We know about single interventions but people with multiple, long-term conditions are the biggest NHS care consumers. So why do we seldom look at the whole person and family and carers? Still we focus too much on the individual disease or condition.

A real outcomes-based approach would look at the whole person and support for their whole life within an annual budget. I think we will move increasingly away from GPs doing 10-minute consultations on an individual disease, to primary care professionals delivering 1-hour sessions on in-depth working with patients' multiple diseases. South Somerset's Symphony programme proves that care can be much more joined up: more effective, cost-effective and improving patient benefits.

The future of the purchaser-provider split

As for the purchaser-provider split, I think we need payers and providers to get better at talking together and we need metrics to inform what makes the most difference. But we still need both roles to be pursued: commissioners on making best use of resources and providers on how best to use the available funding. We need consistent communication, including a louder patient consumer voice in the whole healthcare decision-making process, and to look at changing care across the whole of England rather than in individual, institutional silos.



Most people don't understand that the NHS doesn't fund social care until they know someone hit by a crisis of need.



ANTHONY MARSH

Chief Executive
WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST



Anthony started his ambulance service career in Essex in 1987. He has held a number of senior posts with the ambulance service and has been ambulance chief executive for 14 years.

Our two biggest challenges are money and increased emergency activity. Ambulance trusts like ours, covering multiple clinical commissioning groups (CCGs), see what commissioning looks like when it is done well (and when it is not done well).

We know what outstanding excellence for patients looks like. So our greatest opportunity, which I would encourage across the whole provider sector, is to think of the organisations that we know operate at the very best level, be it commissioning or other. If we as a system can reduce variation to get all organisations up to that level, we can provide even better care with the least spend on bureaucracy, and so the least corporate cost and overhead.

Sometimes in organisations, an individual or stakeholder sets a target, and if most people think that target is unachievable, there will be varying attempts to achieve it. But if we set achievable targets, as others are already achieving now, that removes any argument that 'it might not be achievable'.

And that is how we will be best able to match the very best organisations' achievement. Because most people are competitive by nature, and want to do their best for staff and patients. There are provider organisations and CCGs operating at outstanding level, who inevitably will make further improvements. They want to be the best they can and seek ways to further improve and reduce operating costs at the same time.

Designing pathways for continuous improvement

Providers need to replicate very best practice, but also design pathways for continuous improvement. Ambulance services should all take personal responsibility for doing this. We will always have system levers and governance arrangements allowing commissioning to take place, and we also have the NHS Constitution and licence for provider organisations with respective regulators and legal framework within which commissioning must be conducted.

But across the system, this is about personal leadership and application of personal responsibility for all, regardless of role or where you work within the NHS to realise the ambition to provide world-class patient services and to recognise the huge financial pressure and address it in sustainable ways.

Sustainability and transformation partnerships

We have a great opportunity for the sustainability and transformation partnership (STP) process to be enormously helpful, but STPs will only achieve if they remove lots of other bureaucracy.

For example, over the last year, we have added a new raft of groups and infrastructure – we started off with over 200 CCGs, some of which are now working more closely together. Frankly, that is far too many, and mergers have only reduced by a few.

Then we added system resilience groups, urgent care networks, success regimes, vanguards, STPs, challenged health communities (27 providers whose emergency departments are working with the emergency care improvement programme), turnaround teams – and there will be others.

All of these have been introduced, and nothing has been taken out. That can't be right. STPs can't replace all of these, but we can't keep on piling on new governance arrangements and removing nothing. That makes no sense.

Diversity of commissioning approaches

The development of 'devo' deals and new care models suggest that we will continue to have considerable diversity in how commissioning is delivered across the country. That need be no problem, if there is an absolutely clear direction of travel with the *Five year forward view* and what people are meant to be doing (in terms of the parameters and constraints on implementations).

If you stand back and look at it, we have clarity with the *Five year forward view* and national service frameworks, but all in a context of unhelpful duplication and fragmentation of other governance arrangements. The poor individuals trying to service it all end up with no time to do anything between meetings.

We must always put the patient at the front of what we do, and work backwards. It does seem that with more duplication of the kind I have described that we have lost sight of the aim to improve care for patients and to support our workforce to be the very best they can.

In terms of focus on the patient, we have seen some experiments with outcomes-based commissioning. It will be a good thing to do if we can make it work, but there is a note of caution needed.



We must always put the patient at the front of what we do, and work backwards.



Providing value for investment in commissioning

After 25 years of various reinventions of commissioning, there seems to be a real issue about the scale of NHS commissioning units: both in terms of their size, and the cost of commissioning versus the value added by the commissioning process.

We can cite lots and lots of examples of extensive commissioning arrangements: Cambridgeshire, Hinchinbrooke, NHS111, non-emergency patient transport service ambulance, and many of them collapse shortly after they go live. These are examples of commissioning that clearly didn't work.

So we need to think about whether, given the substantial cost of commissioning, it really provides value for this investment. How does commissioning improve and add value? These examples – small and big – didn't work.



If we set achievable targets, as others are already achieving now, that removes any argument that 'it might not be achievable'.



NICK MOBERLY

Chief Executive
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST



Nick joined King's in November 2015. Prior to this he served as chief executive at Royal Surrey County Hospital NHS Foundation Trust for nine years. Nick previously worked at King's as director of strategic development from 2003 until 2006, when he played a key role in securing foundation trust status. He has held a variety of strategy and management roles in both the public and private sectors. He is a former first secretary at the Foreign and Commonwealth Office, and has worked as a strategy consultant for a range of blue chip organisations.

What is the big challenge facing commissioning today? It is easy to describe: in a nutshell, we have an exceptionally demanding set of expectations in the NHS in terms of the quality of services to be offered; the level of access people can expect to be commissioned; with inadequate funding available to pay for them.

Implicit in that challenge is the requirement for commissioners and providers to drive a transformation and change agenda, which is seriously tough. I have not known a time in recent memory where the tension between quality, access and money has been more marked. That is the challenge for commissioners – and so for providers.

The corresponding opportunities are to seize the moment, and for commissioners who can find ways of working well and collaboratively with other agencies commissioning health and social care to make the most of the funding available and, working with providers, to rethink how services may be delivered.

These are genuine opportunities for progress, and in one sense, it is now a very permissive environment. There is willingness on the part of the Department of Health, NHS England and NHS Improvement to be very flexible and support pragmatic local agreements about how services should be managed.

Sustainability and transformation partnerships

The underlying sustainability and transformation partnership (STP) process recognises that individual organisations on their own can't make the headway and progress that genuinely transforming care requires, so the only way to do improvement of quality and efficiency at scale and pace is for commissioners and providers in broad geographic networks to work on problems together in a collaborative way.

In geographies like south-east London, we have a strong, proud history of collaboration delivering results. Our STP puts a formal shape, structure and timeline to this, helping the process: we have found it helpful and beneficial.

Looking ahead, we will collectively have to work out how to move from a high concept of what might be done to credible delivery plans for hard-edged change on the ground. That is achievable, but tough.

There are potentially significant complexities to think through as we go down this route: what are STPs formally, or perhaps what could they in time become? Are they a planning construct, an accountable delivery vehicle, or a formal part of intermediate-tier NHS governance? We as an NHS system have not thought this through yet. It is important to give this



due consideration and clarity, as whatever we choose will have significant ramifications.

Making integrated care a reality

From a commissioning perspective, with everything under discussion, probably the most significant element of the STPs relates to making integrated care a reality on the ground.

There is unlikely to be a single national definition or prescription of what integrated care is, and how it should be implemented. Different models will emerge in different geographies. However, in many cases the focus is likely to be on commissioning care based on detailed population analysis and risk stratification, using capitated year of care budgets linked to outcome measures, inviting providers to assume delivery risk. And that will profoundly change what both commissioners and providers are, and do.

To date, all we have is small-scale experiments in this direction. None have reached the point of being fully, securely implemented. But over time, in some geographies, we may see the establishment of substantial accountable care organisation (ACO)-type structures, whereby a provider grouping assumes the risk and responsibility for the delivery of care for a substantial sub-regional population.



I have not known a time in recent memory where the tension between quality, access and money has been more marked.

Blurring of the purchaser-provider split

I certainly see blurring of the traditional roles of commissioner and provider ahead. Historically, commissioners have bought specified units of service for a given price. Increasingly, they won't do that: they will be analysing their populations, stratifying according to risk, and setting outcomes-based measures of the health status and improvement they wish to achieve, and allocating providers block sums to deliver those outcomes.

And that means effectively seeking to transfer a great deal of risk to providers. To do so, the risk will have to be properly understood and priced, and providers will have to decide how best and most effectively to plan and deliver the required outcomes within the requisite resource envelope.

The job of buying units of service could therefore go from commissioners to providers and, if so, commissioners would reduce their roles to focus on being more analytical and less hands-on. We will have to see. People need to consider that if they develop strong, functioning ACOs, the commissioning role will not be eliminated, but it could be very seriously reduced.

How far are we away from that? As in the rest of NHS, we are at the very early stages. There's considerable agreement on the direction of travel: join up the system and create integrated services.

But there is a long road ahead to make it a reality. Yet there are interesting opportunities to move fast in the next couple of years. Lambeth and Southwark have formed local care networks, which could be the basis of an integrated care organisation, as has Bromley.

We can move quickly, but nowhere across the NHS have we yet seen integrated care implemented systematically at scale and to a point of demonstrating delivery. Vanguard shows interesting early experiments of what might be achieved.

A more consolidated model of commissioning

From a commissioner perspective, one important issue linked to all of these emerging changes is that of scale. Increasingly, as STPs take hold and sub-regional planning takes place, we have to ask whether CCGs are operating across too small a geography. And in principle, a more consolidated model might make sense as part of a move to novel ways of commissioning, based on integrated, population-based analysis and outcomes-based capitated budgets.

But for that, CCGs would need new significant skills, which are not found anywhere in the NHS on a systematic basis. Not to mention money and capacity.

Moreover, CCGs have done much to address close collaborative relationships within geographies. CCGs have been a significant improvement on the old primary care trust world, with much stronger clinical focus, and in general have made relationships stronger and more productive.

Another challenge: people need to realise that health and social care are a contiguous and fairly seamless set of activities. The challenge for the health side is how to work closely with social care while that is resident in the local authority sector. Both increasingly need to be joined-up – which can work well or badly locally.

In terms of using individual budgets to guarantee a more personalised service, it is unclear how that would work. In principle, you could see a significant disconnect between individualised budgets and an ACO-type approach focused on capitated, risk-stratified budgets for a population. Presumably an ACO would wish to make quite a few of the calls on what care process best delivers a specified outcome.



The future of the purchaser-provider split

There will continue to be a role for a party in any health system to understand population health needs, determine outcomes and allocate funds. Equally, there needs to be a counter-party assuming responsibility for delivering that. That is the difference between resource allocation and delivery. But in terms of how we see the purchaser-provider split currently, the nature of that relationship will change significantly. Even if the future is not clear, the system of payment for units of work undertaken on the payment by results tariff (PbR) seems unlikely to persist in its current form.

But that is looking like a reasonable distance into the future. The PbR model was powerful in a time when the policy focus was to drive down waiting lists when budgets were rising strongly. Getting the finance system right is much harder when the policy focus is about doing the best care within a finite resource base.



As STPs take hold and sub-regional planning takes place, we have to ask whether CCGs are operating across too small a geography.



CAROLYN REGAN

Chief Executive
WEST LONDON MENTAL HEALTH NHS TRUST



Carolyn was appointed as chief executive in December 2015. She is a highly experienced chief executive both in the NHS and in the justice system. She established West London Clinical Commissioning Group in 2012 after spending four years as chief executive of the Legal Services Commission.

We are slightly unusual as a trust: we have a very diverse range of services and we are currently in financial balance. It is interesting to reflect why mental health trusts as a group tend to stay in balance. One reason may be that there has historically been much less focus on mental health services nationally, strategically and politically. So the sector had a bit of time to come up with strategic plans and work out the best way to develop.

Single point of access

I worked on the mental health strategy in north-west London as a commissioner, and I have come back two years later as a provider to implement the strategy. The transformation agenda is huge: the most impact recently has been from our work around the single point of access. All referrals now come through phone or email, which are available round the clock.

The single point of access is staffed by clinicians 24/7, consultant-led in the daytime, and nurse-led out of hours. It is very new, has only been open nine months, and we have had about 4,000 referrals a month. The users are a mix: from GPs; self-referral by patients (some already receiving mental health care, some new patients, and some want signposting information) plus carers and other services like the police. Many GPs say it has been a very helpful resource for getting advice with patients while they are still there in the consulting room. It takes time and energy to get a new model of care up and running and change the way we provide services.

We are developing a host of other things: primary care plus workers with GPs and the primary care teams; dementia link workers; a new perinatal service; an extended child and adolescent mental health (CAMHS) service.

New models of care

It does feel like there is some momentum behind mental health – we are delighted to be part of the CAMHS new models of care work delegated by NHS England in partnership with Central and North West London NHS Foundation Trust. This is a good time for new models of care in mental health and trying new things. It is also about partnership with other organisations and trusts, which were traditionally thought to be strength for mental health and community trusts.

Partnership is seen as a sector strength because it allows space for innovation. Mental health trusts are increasingly providing physical healthcare services: we won two contracts recently to support local people with community independence and reablement services (a natural expansion of what mental health trusts do) and offer



alternatives to hospital admission. We have been in the business of partnership with the local authority and voluntary sectors for many years.

The importance of partnership working

There may be more that mental health services can do to help the whole system respond to the challenges we are now seeing in acute urgent and emergency care services. We know that effective liaison psychiatry can and does help A&E departments and that often, patients attending A&E have both physical and mental health needs. Working in partnership with our acute and commissioning colleagues is the best way to meet these needs and mental health is well-placed to lead some of this work.

Finally, there is a big element of co-production, with patients engaged in strategic planning, recruitment of staff, service redesign and evaluation. Providers wanting to begin working cooperatively should start with something they can deliver, a smallish practical project. Get it delivered, and show partners that you mean what you say about working together.

It is an advantage for staff to have experience of commissioning and providing. I was from a provider background; followed by years of commissioning; then working as a strategic health authority chief executive; then in clinical commissioning groups (CCGs); now I am back on the provider side. I think we need that blend of experience and understanding of the issues on both sides of table, and we see this breadth of experience much less now than we need to.

Common challenges

The challenges facing a commissioner are no different than for a provider: quality and finances. Within that, there is partnership working and innovation: an opportunity to do something radically different and transformative. We know existing services are not sustainable for many reasons, including patients and service users saying so.

So we have to find affordable high-quality vehicles for delivering care for the future, and to innovate. In our daily lives, we use technology and apps, as part of how we live today. We want something on our smartphone that is accessible, responsive and tailored to our individual needs.

Public services could use the tech revolution to provide some of that: personal insights in terms of review/feedback, ongoing inputs and updates and communities of interest. The public sector has been very slow to adapt.

Sustainability and transformation partnerships

The sustainability and transformation partnership (STP) process is clearly meant to drive more alignment between commissioners and providers over a larger footprint. Our track record in north west London

of providers, commissioners and others working together is very good; so we are building on a solid foundation. Others may ask whether the strategic plan is well-known and owned, and it's about taking this on during the next phase of the work. However, it is really about showing deliverables and hopefully not about starting from a blank sheet of paper.

Mental health is absolutely core to our STP, not just in terms of the right quality of care for supporting people with serious long-term problems, but also recognising that staying mentally well and healthy are as important as doing so physically. It is about helping children get the best start in life and helping adults to stay healthy in their homes and communities, and address social isolation: the wider determinants of health.

Our STP also has a vital acknowledgement of the life expectancy gap between people with serious mental health problems and the rest of the population. Addressing that gap is about early identification, good crisis support services, supporting children with mental health problems, and ensuring we consider the physical needs of people with mental health problems and vice versa.

The variation we are seeing emerge, through new care models, more integrated services and accountable care partnerships, is welcome. Let's welcome diversity in delivery and organisational forms that meet local situations shaped by local players, including patients, carers and residents better. We know one size does not fit all.

Saying this, I am assuming we can answer the questions: is enough funding going in; is there good governance, and can we evaluate outcomes for and with service users and carers? If we can say yes to those; then that's great. This whole agenda is about local players working out the key issues for their area, driving transformation and taking people with them.

Commissioner size matters

We know that many CCGs are very small for the job they are tasked to do. Their challenge is to keep the unique local perspective, and also achieve economies of scale. That is about recruiting and retaining the best possible staff. Bigger commissioners have a better chance.

We could retain local CCGs within bigger overall collaborative commissioning arrangements where that makes sense for local decision making but also ensure economies of scale, while avoiding past issues where organisational boundaries got in the way.

When collaboration across an area is starting out, you have to get all the players in a room and have authentic conversations on roles and responsibilities, such as why we are here and what we are trying to solve; how we'll learn from other places and how to manage the risks.



That involves developing different community provider roles. Blurring of the boundaries might be good, to encourage more active movement of staff between organisations – that helps with understanding and perspective. If you can set out, as in any new relationship, what you aspire to and where you are going, what you are trying to solve and how you will measure success, be it over a small community or a large geography, that is the smart approach.

A more personalised approach

The growing emphasis on a more personalised service and personalised budgets is interesting. I worked for a long period in learning disability services, which saw a big move towards personal budgets, and it has been recently floated in maternity care and other services. I think they are a good way of service users having some control over their package of care. Sometimes, it can be very complicated to navigate the system: how you access, what you can pay for and what you need. That can become a bureaucratic exercise in itself, which we can simplify.



The transformation agenda is huge: the most impact recently has been from our work around the single point of access.

But there will be no point in personal budgets if there is no real choice. Some areas have limited choice. In London, with dense and multiple services, personal maternity budgets could work well. People can vote with their feet when they see provider star ratings from other services.

I think consumer-driven reviews will become increasingly important, and mental health services could be at the forefront. We emphasise co-production with users on recruitment panels, transformation and evaluation boards. Patients are teaching us about providing a more personalised service. I think the acute sector has much to learn from mental health here.

The future of the purchaser-provider split

Do I still have faith in the purchaser-provider split, and commissioning in general? Broadly, it is still the basis of NHS relationships, but times have changed. This is a very different world from 25 years ago and we must adapt accordingly. Services now are not about one-size-fits-all: we are more holistic about meeting people's care needs, and there is much more focus on good governance. Finance is more transparent and above board – and that is a good thing. But mental health remains the poor relation.

None of this can be at the expense of trying new things and innovation. So I welcome new care models and organisational forms, and the potential blurring of purchaser and provider roles and responsibilities. Accountable care partnerships will add another welcome dynamic.

Above all, this should be an opportunity to create something new and exciting to meet the needs of our communities.



COUNCILLOR IZZI SECCOMBE

Chairman
LOCAL GOVERNMENT ASSOCIATION
COMMUNITY WELLBEING BOARD



Izzi first came to county politics in 2001 and has held two portfolio roles. Firstly of children, young people and families from 2005-2010, where she brought together the combined services of education and children's services and as adult social care portfolio holder between 2010-2013. Cllr Izzi Seccombe became the first female leader of Warwickshire County Council in May 2013. She has continued to lead her administration with passion, vigour and compassion. Izzi has been on the LGA community wellbeing portfolio since 2013 and has chaired the board since September 2014.

Local government has been actively commissioning services for decades and sees commissioning as a continuous ongoing process, which starts with an assessment of needs, followed by an identification of priorities, market and demand management, contract development and procurement. The NHS sometimes focuses narrowly on procurement, and would benefit from adopting a whole-cycle approach.

Commissioning is far wider than contracting and procurement. Assessing the quality and outcomes of commissioned services is vital to ensure value for public money and to inform future commissioning decisions.

Local government is moving away from commissioning activities or input towards commissioning for outcomes. This approach is person-centred and doesn't just treat individual health conditions. Its focus is on what matters to the individual: what makes their life worthwhile, and what they want to get out of their life.

Once this is agreed, a local authority commissions services to support the person to achieve their goals. The NHS still often commissions for a certain number of units of treatment, rather than using a person-centred approach.

Structure and size

One persistent feature of NHS thinking has been to identify a single 'right-sized unit of planning', but this doesn't exist. Let's accept that some things will be commissioned at specialist/national level, while others will be commissioned at the level of the individual, for example.

Commissioners should be flexible, and understand there isn't just one level of commissioning. The principle of subsidiarity – taking decisions at the right level, and as near to the user as possible – is vital.

Local government has learned that if you have a fantastic contract specification but it does not accurately address need, then providers' services won't always meet those needs or have the right impact.

In my authority, commissioning is the most important thing we do: we can save money and improve services if we get it right. We therefore try to really understand its impact: is it really meeting needs and improving outcomes?

Focus on the individual's wants and needs

Integration is not an end in itself: it is a means of shaping the whole commissioning cycle around individuals' needs. Local government has a longer track record of personalisation, choice and control, but,

increasingly, we need to work together across organisational boundaries to ensure that services are effective in improving outcomes.

Personalising services to the needs of users and future users means really understanding what support they need to live their lives to the best of their ability. This makes co-production hugely important to successful commissioning.

A level, diverse playing field of provision

Maintaining diversity and choice in the residential and domiciliary care provider markets has been hard in times of austerity. Experience has shown that provider market diversity is very important. In adult social care, an increasing number of providers are leaving the market because they no longer see a viable business.

But it is not just about domiciliary support and residential care. Adult social care is leading a shift to more person-centred, preventive models. Small, locally-rooted community or voluntary sector groups are often most likely to maximise their impact for clients' independence, and so provide the most effective services. Heavy-handed or unduly rigorous procurement risks being unfair to these groups. It's important to find a way to level the playing field for those organisations.

Dealing with complexity

Aiming to commission for outcomes rather than activity is challenging for local authority commissioners and their providers, especially when commissioning across more complex care pathways with many providers involved. How providers and contract managers understand this complexity is important. The Commissioning for Better Outcomes Framework¹ developed by the Association of Directors of Adult Social Care, the Department of Health, Think Local Act Personal, ADASS and the Local Government Association raises some of these issues.

Commissioning for outcomes along complex pathways poses a particular challenge for the NHS, as the vast majority of money passes through tariffs based on activity and not outcomes (and unbundling tariffs can be difficult).

Rebalancing the power dynamic between commissioners and providers

We need to develop a 'parity of esteem' between commissioners and providers but this can be difficult because of the imbalance of power and resources, most of which are held by large acute trusts.

1 <https://www.adass.org.uk/media/4576/commissioning-for-better-outcomes-a-route-map-301014.pdf>

Commissioners' challenge is that NHS providers, especially big providers, don't necessarily look to a locality base as their patient flow – and income – comes from far further afield.

Successful commissioning needs an equal conversation between commissioners and providers. In the NHS, that relationship needs rebalancing.

Sustainability and transformation partnerships

Sustainability and transformation partnerships (STPs) are beginning to embed themselves within local health and care systems as the primary unit of planning for health – and to a lesser extent care – encompassing both providers and commissioners.

STP footprints are clearly in the business of managing significant change and redesign of local systems, affecting many organisations. STP processes should ideally help align commissioner and provider plans across these larger footprints, commissioning the right services at the right level.

But STPs need to be an inclusive partnership to improve population health and services. If they are not, then the chances of them achieving their objectives are slim. The lack of involvement of elected members and communities via health and wellbeing boards is an obvious concern for the LGA. We need urgent action to remedy this, as STPs move towards delivery and implementation.

There is real potential for STPs to reshape services for the benefit of their local communities, but they need to be genuine partnerships between health, local government and the community and voluntary sector. The LGA urges senior leaders to be involved and influence local conversations.

Working with clinical commissioning groups, and local-vs-national tensions

We have a national health service and national inspection and monitoring, but local government and local clinical commissioning groups (CCGs). How does the national framework support local provision and place-based approaches?

While CCGs are relatively new organisations with huge challenges, one very positive aspect is that they are clinically-led. In most places, any concerns about CCGs from local government about how new GP-led bodies might relate to and work with partners in local government, have been dispelled by experience of working together.

In practice, we found we shared many values. CCG commissioners have a clear sense of place, and of the patient as a whole person with assets beyond their health challenges. In the main, local government has



worked well with CCGs that have worked hard to move beyond thinking in very health-centric, internally-focused terms of NHS services, and reflected on how best to work with local government. They have developed and matured significantly in just a few years, as have health and wellbeing boards. Any reshaping of health systems, such as developing accountable care systems must build on the partnership working between health and local government, rather than undermining it.

Local-versus-national tensions do not only affect CCGs: the entire NHS gets pulled in two different directions. Acute contracts are mostly left with the CCG, who work with local government partners on place-based approaches, while also working to national frameworks and performance targets. That is uncomfortable and makes it very hard to satisfy both constituencies.

Commissioner-provider split

Local government's clear distinction between commissioning and provision means we do not necessarily see it as an insuperable conflict of interest if both functions are located in one organisation.

That requires a level of independence and challenge if commissioners are providing services, so there is a level playing field for in-house and other providers, to secure best value for money and best outcomes. If no providers are involved in your commissioning planning, you may not understand the whole picture of their potential impact, and what you might need.

We can get very precious about who sits at the table on conflict of interest grounds, but all participants must focus on what they're trying to achieve together. It is public money, so we have to show that decisions are reached in a fair, proper and value-for-money way.

The purchaser-provider split is an evolving, non-static situation. As with the NHS, local government is a world of continual change. There will be movement around where the payer-provider split happens. I hope we deliver integration and deliver around commissioning for the future.



Integration is not an end in itself: it is a means of shaping the whole commissioning cycle around individuals' needs.

Useful learning

Ultimately, there is useful learning for the NHS from local government's approach to commissioning. It is about so much more than contracting and purchasing and, when seen in this light, the role and value of commissioning can be truly appreciated.



KATHERINE SHEERIN

Chief Officer
NHS LIVERPOOL CLINICAL COMMISSIONING GROUP



Katherine graduated from Liverpool University in 1992 and joined the NHS general management training scheme. Her final placement was working with GPs in Old Swan Health Centre and since then she has worked in a number of primary care and commissioning roles in Liverpool before becoming chief officer for NHS Liverpool CCG in 2012.

Commissioning in the NHS faces hugely evident challenges, of which the biggest is money. There is simply not enough money in the health and social care system, so we're facing difficult choices, which we're making after difficult conversations with providers and system leaders.

The impact of funding constraints

There are financial shortages across the whole system. Dealing with them as best we can means aligning commissioners – across clinical commissioning groups (CCGs) with NHS England and local authorities – all working together to meet this challenge.

Liverpool CCG is responsible for half a million people, and we are the lead CCG for 7 providers, and 93 GP practices. But even as one of the largest CCGs, we don't necessarily have the capacity to deal with the current challenges.

We've got great clinical leadership in Liverpool CCG, lots of it: we fund it properly. We had shadow running as three distinct patches, and that didn't work well and we committed to using the economies of scale from having one CCG for the city to invest in clinical leadership and engagement across commissioning and provision. It's all about that clinical leadership, which is probably as strong in Liverpool as anywhere else in the country.

Reforming CCG size and configuration

CCG size and configuration are issues. They'll probably have to change, whether by formal mergers from the points of view of capacity and coherence. As providers coalesce, chains of providers develop for more integrated provision, the system can't have a plethora of small commissioners trying to solve ever bigger problems. However, we mustn't lose local intelligence and engagement. It's about what works. Regardless of shape, we need ways to keep local clinical engagement.

Of course there are also opportunities for CCGs, NHS England and local authorities to work together to effectively pool skills and capacity, and lead and engineer change on a bigger footprint for health and social care services. The sustainability and transformation partnerships (STPs) are definitely an opportunity if we get the footprint right. If the footprint becomes too big, you'll lose the vital local understanding of how we can get to the end we need.

STPs

STPs can be a good vehicle for bringing people together to work out how to do all that (and how to influence at different levels). STPs vary in size, complexity and characteristics, so what works in one STP for primary and



secondary care transformation won't automatically be transferable to another.

Size and geography matter at this level too. Our STP population is 2.5 million, of whom 800,000 are in our north Mersey region, which centres around Liverpool and is very compact. So we can do more in north Mersey, more quickly. Changing care for the same population in a more spread-out geography will take much longer. The STP has added to the climate to allow change to happen, which might otherwise have been harder.

How devolution deals will affect commissioning has become more unclear since the EU referendum result. Some things have been devolved to our combined authority (Liverpool City Region), but not health and social care. It's hard to see whether the devo trend will continue. [Former chancellor of the exchequer] George Osborne was very pro-devo.

I suppose that while the government is tied up in EU negotiations, it gives us time for thinking about how a form of devolution could work for us.

We had wanted our STP footprint to match the combined authority footprint as if we were later going to devo, there would be no overlaps. With clear messages that STP footprints may be given more autonomy we will probably need to re-visit our footprint to make sure it makes sense.



There are opportunities for CCGs, NHS England and local authorities to work together to effectively pool skills and capacity, and lead and engineer change on a bigger footprint for health and social care services.

Blurring of the purchaser-provider split

New care models and new organisational forms do blur the purchaser-provider split. These discussions are part of our north Mersey local delivery system plan. All north Mersey provider and commissioner chief executives meet fortnightly with local authority representatives to ensure that we are making progress against all our aims, including reconfiguring hospital services, meeting more demand for services in the community and acting as one system.

In terms of specialised services, some commissioning will always stay very national and not involve us, but a lot of stuff is coming back locally. This makes sense as decisions on those services need to be considered alongside local services, and vice versa. So specialised trusts and services need to be part of the local level where possible, and only regional/national where necessary. Our hospital line is 'local where practicable; central where necessary'.

The need to reform primary care

We went straight to co-commission primary care, and I think that should always have been CCGs' task. There was a hiatus for two years while NHS England had responsibility and, as with specialised services, decisions need to be taken collectively. We sorted out a primary care wrap-around



service (the Liverpool GP specification), which we commissioned as a locally enhanced service under the primary care trust, and continued with it as we transitioned into the CCG so we could keep developing and improving primary care. We have got to sort out primary care. If we do, the NHS could be sustainable; otherwise it's very unlikely to be.

We've looked at outcomes-based commissioning. Our example is diabetes care: we sought the professionals' advice, pooled budgets between hospital and community services, with the hospital as a lead provider. Our contract now builds incentives for the hospital to do less complex activity by ensuring that patients are seen more proactively in the community. It has proved successful by getting the hospital and community providers together to work in more focused ways, and is already resulting in better outcomes for patients.

So, you absolutely need to build in outcomes to contracts wherever possible. Like our GP specification, which has resulted in 20,000 'missing' people being included on disease registers. In primary care trust days, we had the national support team for health inequalities review our approach in Liverpool. At that time they said that there were about 20,000 people missing from our disease registers. Through the GP specification, we have identified many of them, and ensured that they are being managed appropriately. This has resulted in reduced emergency admissions for these groups.

The future of the purchaser-provider split


In terms of the purchaser-provider split and the future of commissioning in general, there will always need to be something – a needs assessment function, which sets outcomes and quality standards, pays providers and then monitors delivery, taking action where needed.

Some of what we do now may happen more in the provider system in future, for example service redesign, but we will still need strategic oversight and a way of holding the system to account.



Commissioning in the NHS faces hugely evident challenges, of which the biggest is money.





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