

Thinking differently about commissioning

Learning from new approaches to
local planning

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Key messages

- Big changes are taking place in national NHS policy in England, as collaboration replaces competition as the key tool for improving services. As a result, some parts of the country are reimagining how they commission services. While these places differ in how they are approaching implementation, they share a common philosophy of commissioning focused on co-operation and joint ownership of risk among commissioners and providers and, when this co-operation is most developed, across the NHS and local authorities.
- The role of commissioning within the English NHS has long been contested. Arguably, the theory of a commissioner-led system has never been realised in practice due to the power of providers and national NHS bodies. These new collaborative approaches hold out the prospect of moving beyond these debates by allowing commissioners to take their place within systems that share ownership of challenges and responsibility for service improvement.
- Our case studies – three clinical commissioning groups (CCGs), or groups of CCGs that have adopted this approach – found that it affects all parts of the commissioning cycle: planning, procurement and monitoring. Broadly, their focus is shifting away from procurement towards other parts of the cycle, with changes largely being implemented within existing organisational structures.
- Implementing these collaborative approaches successfully requires a focus on the skills of staff working for commissioner and provider organisations, as they are being asked to work differently. After nearly 30 years of quasi-market arrangements, staff need support to test and embed new ways of working. Investment in leadership and organisational development is critical to delivering this change.
- As new approaches to commissioning develop and systems increasingly focus on population health, clinical involvement in commissioning will need to evolve. A wider range of professionals – spanning different clinical groups and other public service professionals – will need to contribute to commissioning processes in the future.



- Our case studies illustrate the benefits of strong place-based planning in which providers and commissioners collaborate over smaller geographies. Current national policy is for integrated care systems (ICSs) to span England and typically be co-terminous with CCGs. Yet merging CCGs by default risks undermining these local collaborations. NHS England and NHS Improvement should work with local leaders to take decisions about the size and structure of CCGs on a case-by-case basis.
- As ICSs and sustainability and transformation partnerships (STPs) develop further, supporting these place-based planning collaborations should be central to their role.
- The regional teams of NHS England and NHS Improvement have an important role to play in supporting the development and spread of these models. We heard that there is currently variation in their approaches, with some more permissive than others in supporting local autonomy and a shift away from a procurement focus. As new approaches develop across the country, consistency in regional oversight will be critical to ensuring that innovation is not stifled and that risks are managed effectively.
- The existing model of assurance among national NHS bodies remains mostly based on organisations rather than on systems, and our case studies are running dual processes to satisfy national bodies' assurance needs. This incurs unnecessary costs and may hamper progress. While more collaborative commissioning approaches bring risks that need to be managed (for example, in relation to conflicts of interest), the existing model of assurance is yet to strike the right balance between organisational and system-level scrutiny as well as national versus local line of sight.



1 Introduction

NHS commissioning was created almost 30 years ago with the establishment of the internal market. This split the planning and provision of services into separate organisations so that competition and market incentives could be used to promote efficiency and improve quality.

Over the past five years, the emphasis of NHS policy in England has shifted towards promoting collaboration rather than competition as the key tool for improvement in the health system (albeit with a mixed system still operating on the ground).

As part of this shift, providers are increasingly working together to develop more co-ordinated services for patients, stimulated by the new models of care set out in 2014 in the *NHS five year forward view* ([NHS England et al 2014](#)). The NHS is also, in some places, joining up elements of its budget and decision-making with local authorities to support the integration of health and social care ([Local Government Association et al 2018](#)). At the same time, commissioners and providers are collaborating to plan services collectively, most notably through the STPs that were established in 2016 and the ICSs into which the most advanced STPs have evolved ([Ham 2018](#)).

These changes are taking place to different degrees in different parts of England. In those places where change is most advanced, the purchaser-provider split in the NHS still exists, but it is blurred, and it is no longer straightforward to delineate 'commissioning' activities using organisational boundaries. While there has been no change to the NHS's legal framework, and the statutory roles of commissioners and providers still stand, some providers now undertake commissioning-type roles and – as with the STPs/ICSs mentioned earlier – some local planning is done collaboratively across the purchaser-provider divide.

These trends have profound implications for the role of commissioning organisations in the NHS. With some core aspects of their role in supporting the market falling away, they are starting to work out new ways to support system-wide collaboration. Providers and commissioners in local areas have been developing their commissioning approach in different ways, supported by a national



policy direction that allows local variation. Neither the NHS long-term plan nor the Forward View provided a blueprint for the future shape of commissioning. This means that some areas are further along than others in moves to shift the role of CCGs to fit the changing environment in which they operate.

Our research

This report seeks to understand these developments and support CCGs and local health and care systems to evolve their commissioning approach. It aims to:

- understand the approach being taken by some CCGs and local systems that are rethinking the role of commissioning
- draw out learning for other areas as they work to change their approach
- explore the national policy implications of this new way of working and what national NHS bodies can do to support its development.

To do this, we identified three CCGs or groups of CCGs that are thinking differently about their role. These are CCGs that have developed a clear vision for a new, more collaborative approach, and have started to use this to change the way they undertake their day-to-day commissioning work.

These CCGs were identified through The King's Fund's work with commissioners across England and a series of scoping conversations with government and national NHS bodies. They are:

- South Tyneside
- Tameside and Glossop
- Bradford district and Craven.

We visited these CCGs and interviewed a range of staff from NHS, local authority, commissioner and provider organisations, completing 39 interviews in all. We asked interviewees to describe their approach to commissioning and how this was affecting their day-to-day commissioning work, and analysed relevant data and background documents from each system. We also held a roundtable with



commissioners from other parts of the country, national NHS bodies, academics and other representative organisations to discuss the implications of our findings. Finally, we reviewed existing evidence on commissioning in the NHS over the past 30 years and commissioning in other parts of the public sector to enable us to put developments in these three CCGs into context.

For more detail on our methodology, see Appendix A. For additional background information about our case study sites, a summary of evidence from past commissioning initiatives, and a summary of key points from the roundtable held to discuss emerging findings, see Appendices B, C and D respectively.

The structure of this report

Section 2 puts our case studies into context. It includes a brief description of past models of NHS commissioning, an outline of the changes shaping health and care commissioning today, and a discussion of broader trends in planning across the public sector. Section 3 outlines the approaches taken in each of our case study sites, exploring the context, the approach being developed, and what it means for how those commissioners deliver their functions. Section 4 then looks across the case studies and identifies common themes. In Section 5 we outline learning from these case studies for other local systems and the implications for national policy.



2 Policy background

This section sets the context for our case studies by providing a brief account of the terrain in which they operate. It starts by exploring what lessons can be learnt from past experience of NHS commissioning. It then outlines the latest developments in NHS commissioning and briefly discusses trends in the planning of wider public services.

What is NHS commissioning and how is it changing?

At its most basic, NHS commissioning involves planning health services to meet populations' health needs. This planning role has been required throughout the history of the NHS. How it is done has changed substantially over time, however, and continues to evolve today. Before turning to the latest developments, we briefly explore what lessons can be drawn from past experience of commissioning within the English NHS.

NHS commissioning – past experience

The introduction of a purchaser–provider split in 1991 inaugurated a new era in NHS planning. From this point, local commissioners were established as independent entities, holding budgets, carrying legal responsibilities, and empowered to contract with functionally separate service providers to meet populations' needs.

While this fundamental separation has remained ever since, the mechanics of commissioning have been subject to frequent reorganisation. A drive to increase the involvement of clinicians in commissioning has been central to many of these changes. The box below provides a thumbnail timeline of the key models of NHS commissioning (more detail on these models is provided in Appendix C)



Key models of NHS commissioning, 1991 to date

Health authorities and GP fundholding, 1991–9

With the introduction of the internal market, district health authorities were handed responsibility for commissioning the bulk of health services. Alongside them, GP practices (or groups of practices) were given the option to take control of budgets to commission some hospital care and community services for their patients (particularly elective hospital care and community services). Health authorities retained overall responsibility for commissioning services.

Locality commissioning, 1994–9

Alongside fundholding, a number of alternative models emerged bottom-up. Locality commissioning, as one example, focused on enabling GPs and local residents to input into health authorities' commissioning decisions to shape local services. The practical mechanisms varied but included organising structured engagement opportunities rather than taking on responsibility for delegated budgets.

Total purchasing pilots, 1995–9

Envisaged as an evolution of fundholding, total purchasing offered groups of GP practices the opportunity to commission a wider spectrum of (theoretically all) hospital and community services. In practice, the participating pilots generally focused on a few key service areas such as community and mental health services.

GP commissioning, 1998–9

With the arrival of New Labour in office, GP fundholding was halted. In its place, GP commissioning involved a range of models to allow GP practices to input to health authority commissioning decisions.

Primary care groups, 1999–2002

Where participation in previous models had largely been voluntary, primary care groups were nationally mandated. Their commissioning responsibilities spanned primary, community and hospital services, and they were intended to evolve over time from advisory entities to autonomous budget-holding organisations.



Primary care trusts, 2002–13

Originally intended to be the eventual end state for primary care groups, primary care trusts (PCTs) were in fact rolled out nationally in 2002. Hybrid organisations, PCTs commissioned the bulk of health services, provided some community services (until these were eventually hived off into separate organisations) and were responsible for public health improvement.

Practice-based commissioning, 2005–13

Intended to rectify some of the perceived weaknesses of PCT commissioning, practice-based commissioning offered groups of GP practices (encompassing GPs, nurses and other primary care professionals) indicative, or virtual, budgets to commission a range of services with a focus on hospital care. PCTs retained overall legal responsibility.

Clinical commissioning groups, 2013 to date

The Health and Social Care Act 2012 created 211 CCGs across England with budgetary responsibility for commissioning mental health, community and acute health services (replacing PCTs as the key local commissioning organisations). These CCGs formally came into existence in April 2013. GP practices were required to be members of their local CCG, and CCG governing bodies had to be chaired by a clinician.

Looking across the evidence about the past experience of commissioning within the English NHS, a few key points stand out, as follows.

- Clinical involvement in commissioning seems to support innovative approaches (Miller *et al* 2015). GPs, for example, have been found to add value to commissioning through bringing crucial ‘frontline’ insight (McDermott *et al* 2015). Consequently, clinical involvement in commissioning decisions enjoys widespread support today, but how best to structure clinicians’ involvement in commissioning is still a live discussion. Previous research by The King’s Fund found that GPs were more engaged in CCGs compared with previous models but highlighted outstanding questions about how to sustainably involve clinicians in commissioning work and increase the range of clinicians and other



health and care professionals who are involved through these approaches (Robertson *et al* 2016).

- Evidence linking commissioning with a positive impact on costs or the quality of health care services is limited (Gardner *et al* 2016). How commissioning is implemented is likely to be crucial to generating its envisaged benefits (and needs to be balanced against the overheads of running a commissioning system). International experience shows that health systems around the world have struggled to develop effective commissioning functions (Klasa *et al* 2018; Ham 2008).
- Finding the optimal geographical or population size footprint for commissioning organisations has been a recurring challenge. As the timeline of commissioning models (see box, p 11) illustrates, various configurations have been experimented with; some have prioritised granular local insight and engagement, while others have prioritised the benefits of scale. There is, as yet, no definitive evidence pointing to an optimal population footprint for commissioning organisations. Rather, the prevailing view is that different services suit commissioning at different population footprints (Lorne *et al* 2019; National Audit Office 2018).

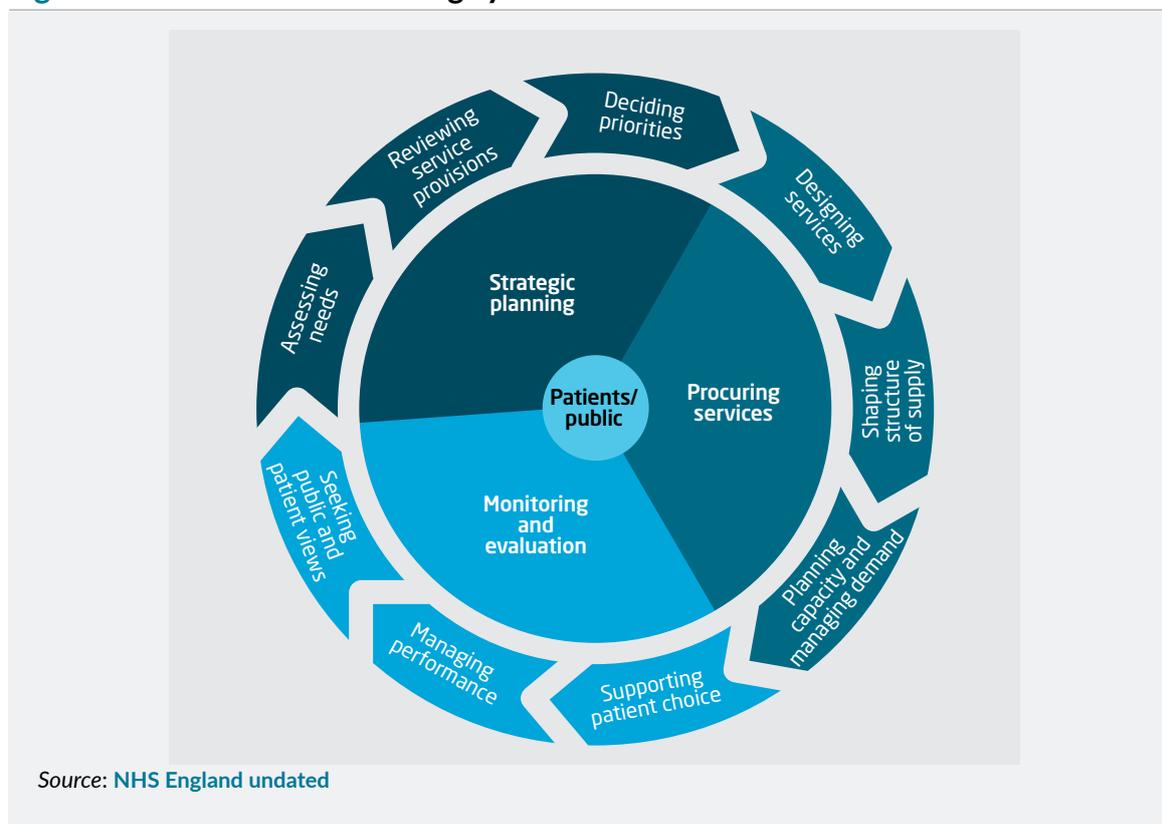
For a number of reasons, what it is possible to say confidently beyond this is limited. Frequent reorganisations – and the attendant upheavals for staff – have hampered learning and the tracking of impact. Changing geographies of commissioners have compounded this challenge. Contemporaneous evaluations have not always been funded (although researchers have generated evidence retrospectively). And changes to commissioning arrangements occurred within an ever-changing environment, meaning that learning was often context-specific.

NHS commissioning – the current context

In health care in England today, commissioning is often represented as an ongoing cycle (see Figure 1), which includes the following component functions:

- understanding the needs of local populations
- planning services to meet those needs
- contracting with providers to deliver services

Figure 1 The NHS commissioning cycle



- monitoring and holding those providers to account for delivering services
- involving key stakeholders, such as the public, in decision-making.

The most recent major national reorganisation of health and care commissioning responsibilities occurred with the Health and Social Care Act 2012. Broadly, it introduced a three-way division of responsibilities:

- CCGs would commission the bulk of local health services
- NHS England would plan specialised, primary care services (including community pharmacy and dentistry) and some other services such as care for people in the criminal justice system
- local authorities would be responsible for social care, some public health services (eg, sexual health and addiction services) and wider public services that affect health, such as transport, housing and leisure facilities.



For more details on the arrangement of commissioning responsibilities see [Wenzel and Robertson \(2019\)](#).

Although there has not been statutory reform of commissioning since 2013 (when the Act was implemented), the mechanics of commissioning continue to develop. Below, we outline key trends in the changing commissioning landscape.

Changing responsibilities

Gradually, the separation of commissioning responsibilities brought about by the 2012 Act is being reversed or blurred. Nearly all CCGs have now taken on delegated responsibility for commissioning GP services (although legal responsibility still sits with NHS England) ([NHS England 2017](#)). More recently, CCGs have been asked to take on a greater role in commissioning public health services collaboratively with local authorities ([Department of Health and Social Care 2019](#)). NHS England has also signalled that local systems – STPs or ICSs – are set to play a greater role in commissioning specialised services ([NHS England and NHS Improvement 2018c](#)).

Over the same period, a number of policy initiatives have attempted to stipulate how CCGs spend their budget in some important areas. For example, both general practice and mental health services are subject to national policies that effectively set how much resource CCGs devote to these service areas ([NHS England and NHS Improvement 2019d, e](#)). The Better Care Fund sees a growing slice of CCGs' funding – a minimum of £3.8 billion in 2019/20 – earmarked for inclusion in joint planning arrangements for health and social care ([Department of Health and Social Care and Ministry of Housing, Communities and Local Government 2019](#)). And CCGs have been instructed to offer personal health budgets to a range of groups with complex needs, including people in receipt of Continuing Healthcare, those with ongoing mental health needs or those with autism or learning difficulties ([NHS England and NHS Improvement 2019g](#), p 25).

New collaborative approaches to planning

Alongside taking on responsibility for broader portfolios of services, CCGs are increasingly collaborating with other commissioners in their local area. In tandem with the Better Care Fund process, a range of models are emerging to deepen joint working between CCGs and local authorities, with a focus on health and social care planning. Some parts of the country are delegating planning responsibilities for both service areas, to either the CCG or council. In other places, like Northumberland,



senior leaders are taking on joint roles that span the NHS and local government. Some parts of the country, such as Tameside and Glossop (discussed in Section 3), are effectively merging CCGs and local authorities to create single planning bodies for most local public services.

The NHS long-term plan indicated that NHS England will continue to support the fusing of NHS and social care planning arrangements, focusing on four approaches:

- pooling budgets
- personal health and social care budgets
- delegated authority models
- shared leadership arrangements.

System-wide collaboration is developing through STPs and ICSs. STPs were first established in 2016, bringing together commissioners and providers to plan collectively across local areas. Since then, some STPs (14 at present) have been designated as ICSs based on the maturity of their system. ICSs enjoy greater autonomy from national NHS bodies and more responsibility for managing resources and local performance as a single system. The NHS long-term plan committed to all STPs becoming ICSs by April 2021 ([NHS England and NHS Improvement 2019g](#), p 29).

The effect of these changes is to see CCGs planning services – and contributing to change programmes – at a number of different population footprints. [NHS England and NHS Improvement \(2019b\)](#) currently describes this in three tiers, as follows.

- **Neighbourhoods** – which generally cover populations of around 30,000 to 50,000. The service focus at this level is generally on strengthening and extending primary and community services – for example, through the development of integrated teams.
- **Places** – which include populations of approximately 250,000 to 500,000. This is often where resource allocation decisions are taken, where co-ordination with local authority colleagues is strongest, and where integration work between hospital, community health and social care services occurs.



- **Systems** – which generally cover populations of around 1 million to 3 million and refer to the area covered by ICSs/STPs. Responsibilities can include some commissioning – for example, specialised services and ambulance services – as well as setting system priorities, developing governance arrangements and supporting cross-cutting programmes such as work on digital and estates.

In practice, the optimal population size for a local system depends on its geography. Some ‘places’ naturally serve populations smaller than those outlined in this schematic. For example, South Tyneside, discussed in Section 3, serves a population of around 150,000. Similarly, the footprints of STPs and ICSs vary and are likely to differ in the functions they choose to locate at the ‘system’ tier. NHS England and NHS Improvement’s recently established joint regional teams operate above these tiers, providing oversight and support to emerging local systems – spanning both commissioning and provider functions.

NHS England has outlined an expectation that ICSs will gradually develop their capabilities to manage resources and deliver performance management functions at ‘system’ level. In turn, this will allow NHS England and NHS Improvement to simplify its assurance relationship with local organisations. Over recent months, STP and ICS footprints across England have been developing five-year plans to translate the NHS long-term plan’s commitments into plans for their area.

Joint leadership arrangements and mergers

Alongside participating in system planning efforts through their ICS or STP, many commissioners are planning services across populations that are larger than their original 2013 footprint (again, undoing the legacy of the Health and Social Care Act, which reduced the scale of local commissioning organisations).

Shared leadership arrangements have been developed by many commissioners. In London, the CCGs in the five STP footprints have come together under single accountable officers ([Eddie 2018](#)). In some places – for example, Bradford district and Craven (one of the three case studies) – shared leadership arrangements have acted as a precursor to a merger.

Elsewhere, commissioners have opted for full merger. As of April 2019, mergers had reduced the total number of CCGs in England from 211 to 191 ([NHS England and NHS Improvement 2018a](#)). This number is expected to fall further, partly due to



a need to generate savings in management costs (NHS England has asked CCGs to cut their running costs by 20 per cent between 2017/18 and 2020/21 to free up resources for investment in frontline services) ([Brennan 2018](#)).

The NHS long-term plan gave CCG mergers added impetus by indicating that CCGs will ‘typically’ be co-terminous with ICSs. Since then, a substantial number of local systems – including parts of London, the South East, South West, the Midlands, Yorkshire and East Anglia – have indicated that they will be merging their CCGs in April 2020, with more mergers expected in April 2021 ([Collins A 2019](#); [Hignett 2019a, 2019b](#); [Illman 2019](#)). While it remains to be seen how far the consolidations will go, some commentators have hypothesised that within a couple of years, there will be 60–70 CCGs left across England ([West 2019](#)).

New approaches to reimbursement and contracting

The Health and Social Care Act reforms were based on a system of commissioning in which commissioners used nationally set prices to reimburse acute providers. The aim was to stimulate competition among a mixed economy of provider organisations – NHS, independent and voluntary sector – to drive up service standards, with resources following patients. Today, this dispensation is gradually being unpicked as commissioners change how they reimburse and contract with providers.

Many CCGs are moving away from Payment by Results (PbR), the volume-based payment system for acute services. In its place, a number of local areas – for example, Bolton and Leeds – have developed ‘aligned incentive’ contracts ([Dunhill 2018, 2017](#)). [NHS England and NHS Improvement \(2019c\)](#) has signalled a further national move in this direction with the development of a blended payment for emergency care, and proposed changes to reimbursement for some planned care as well ([NHS England and NHS Improvement 2018b](#)). Gradually, activity-based payment for acute care is becoming less common.

Commissioners are also experimenting with novel contracting approaches to bring together different funding streams to support the integration of services ([Collins B 2016b](#)). These are taking various forms in different parts of the country. Alliance contracting is a particular area of interest because of its potential to support coalitions of willing organisations – commissioners and providers – to establish long-term legal relationships and share risk ([Addicott 2014](#)). Lambeth CCG, for



example, has commissioned an alliance of local providers on an initial seven-year contract to deliver a range of adult mental health services, including improving access to psychological therapies, crisis support, peer support and mental health social work ([Hutchinson 2019](#)).

Other areas are exploring related approaches that ask coalitions of providers to come together to deliver portfolios of services under a single contractual arrangement (sometimes known as prime provider or lead contracts). To support this, NHS England and NHS Improvement has developed a contract for commissioning an integrated care provider (ICP), which uses a whole population budget (a form of per-person payment) and outlines an assurance process that local systems will need to go through if they intend to use it ([NHS England and NHS Improvement undated](#)). It is not clear how many parts of the country plan to take this approach. But Dudley CCG, for example, has been exploring procuring a long-term contract spanning a range of out-of-hospital services, including community, mental health and learning disability, primary care, end-of-life and intermediate care ([Dudley NHS Clinical Commissioning Group 2019](#); Batty and Maubach 2018).

The evidence base for the effectiveness of contractual models of these types is limited, particularly when applied to health services ([Sanderson et al 2016](#)). Previous experience of implementing these approaches within the NHS has pointed to a number of practical challenges, particularly around poor data quality and high transaction costs ([Collins B 2016a](#)). More broadly though, these approaches represent an evolution in the division of labour between providers and commissioners. Under some of these arrangements, providers take on responsibilities – managing resources, service transformation and performance management – that traditionally would have sat with commissioners.

How is broader public sector commissioning changing?

Many of the changes to NHS commissioning that we have outlined sit within broader trends across the public sector. In this section we briefly review some of the key developments relevant to the work of our case studies.



Evolution of commissioning

The scope of services subject to commissioning has increased over time. Early efforts in the 1980s generally focused on support services such as laundry or refuse collection. In local government, this was extended to other support services in time (Szymanski 1996; Wilson and Game 1998). During the 1990s, the scope of services with a functional separation between planners and providers increased so that by the 2000s, a swathe of public services – criminal justice, children’s services, employment services, leisure services – effectively had commissioning functions.

The ambition and complexity of commissioning approaches has increased over the years. In the early days, competitive tendering was arguably seen as the dominant tool for driving service improvements. The New Labour governments saw a gradual evolution of the commissioning concept – they spoke of ‘strategic commissioning’ – which placed greater emphasis on understanding needs, working in partnership with providers to drive improvement, and actively monitoring and managing performance (Rees 2014; [White 2011](#)). The commissioning cycle that informs health commissioning today has its origins here (see Figure 1).

These domestic developments have been reinforced by European Union (EU) policy, which, over time, has supported the extension of commissioning disciplines across public services. With a view to promoting the functioning of the single market, the EU has developed rules on public procurement focused on ensuring a level playing field between prospective providers, as well as transparency ([Becker et al 2019](#)). The UK’s 2015 Public Contracts Regulations gave effect to an EU directive of this type. Commissioners have needed to demonstrate compliance with these rules.

The portfolios of services included in individual contracts have increased over time as well; in place of tendering for individual support services, commissioners today are willing to bundle together complex packages of user-facing services. This has been seen in areas such as rehabilitation services for offenders and employment support services ([National Audit Office 2019](#)). To enable this and to facilitate groups of providers to work together, commissioners have experimented with contractual tools (much like NHS commissioners) – for example, prime contracts have been used in the delivery of employment support services ([Crowe et al 2014](#)). Related trends have been seen in a number of local health economies ([Collins B 2019b](#)).



Outcomes have become increasingly prominent in the commissioning discourse over the past 20 years or so. Public service commissioners (and charitable foundations) became increasingly interested in the notion of making reimbursement conditional on providers delivering certain ‘outcomes’, rather than paying for volumes of processes (Moss 2010). Different versions of outcomes-based reimbursement have been used across public services – for example, programmes to support troubled families (National Audit Office 2016) and to help people who are long-term unemployed back into work (National Audit Office 2014). These concepts fed into health services and social care, with some local areas introducing outcomes-based contracts across a range of physical and mental health services (Bolton 2015; Taunt *et al* 2015).

Today, there is an ongoing debate on the effectiveness of outcomes-based commissioning. Accumulated experience has pointed to a number of practical challenges: providers are able to game outcome measures (Tomkinson 2016); designing meaningful, insightful outcomes measures is far from straightforward (Collins B 2019a); and commissioners have found it hard to design reimbursement mechanisms that allocate manageable levels of risk to providers (National Audit Office 2015).

A new wave of commissioning approaches

All the trends outlined above continue to develop. In recent years these have been joined by a new strain of thinking focused on collaboration as a tool for public service improvement. A range of places around the country are testing ways of working – across different public services – informed by these ideas (Blundell *et al* 2019).

A number of factors have been invoked to explain this conceptual turn. Public service leaders are seeing service users’ needs growing and becoming more complex (Davidson-Knight *et al* 2017). The long-term fiscal outlook suggests there will be continued spending restraint and an (additional) imperative to shift resources towards prevention (Office for Budget Responsibility 2018). Across many advanced welfare states, digital technology is opening up new possibilities for public service delivery; at the same time, market-based approaches as tools for sustainable service improvement have been coming under more sustained questioning (Ham 2014; Dunleavy *et al* 2006).



Arguably, emerging collaborative planning approaches are yet to coalesce into a single body of thought; rather, there are a number of approaches co-existing that share some common elements. Different terms are being used to refer to approaches in this area, including collaborative commissioning, asset-based commissioning and community commissioning (for examples, see [Lent et al 2019](#); [Burbidge 2017](#); [Davidson-Knight et al 2017](#)). Each approach emphasises slightly different notions, but some key ideas often feature prominently, as follows.

- In place of measuring the technical efficiency of individual services, there is a focus on collaboration between different services to meet the full range of people's needs. These approaches often focus on intractable problems such as homelessness, substance abuse, loneliness and repeat offending.
- The attitude towards frontline staff – and how they are supported – is central to these approaches. Rather than mandating staff to follow operational rules and guidelines, emphasis is placed on empowering them as autonomous professionals to use their judgement in meeting service users' needs.
- Rather than arm's-length relationships between commissioners and providers, whereby commissioners are agnostic about how services are delivered (sometimes known as black-box commissioning), these approaches envisage close, ongoing dialogue between providers and commissioners so that both partners are fully aware of operational demands.
- Instead of funding mechanisms that allocate risk to providers, commissioning approaches informed by these ideas generally develop long-term, predictable financial arrangements that make it possible for commissioners and providers to maintain an honest dialogue about delivery.
- The value of experimentation is emphasised: operational ideas are tested, amended, rolled out or abandoned (and failure is embraced as a learning opportunity) on an ongoing basis. This is in contrast with long-term contracts that can serve to lock in particular operating models.
- At the centre of these approaches is a behaviour change process for staff who are asked to work together differently (both within commissioning organisations and with provider organisations). It involves overcoming traditional organisational or territorial demarcations and focusing on shared endeavour and mutual support.



Around England there are places implementing approaches that operationalise some of these concepts. Examples include Wigan ([Naylor and Wellings 2019](#)), Plymouth ([Local Government Association 2018a](#)), and Preston ([Centre for Local Economic Strategies 2019](#)). It is still relatively early days, and while there are already some promising signs, the long-term results of these approaches remain to be definitively established. Their emergence, however, tells us something about the evolution of thinking among public service planners.

Conclusion

There has never been a fixed, single approach to commissioning; rather, there is an evolving spectrum of approaches. Today, interest is being drawn to the collaborative end of this spectrum.

In turn, this emerging paradigm of collaborative ideas is feeding into how commissioners in a number of public service areas are organising themselves and delivering their functions. Within the NHS, commissioners are working over larger footprints, planning a wider spectrum of services, drawing together funding streams, and working more closely with other organisations involved in commissioning services (such as local authorities). Where once the primary tool for driving service improvement was competitive procurement, today commissioners are increasingly supporting collaboration across local systems via new reimbursement and contracting arrangements that foster long-term partnerships.

Progress on this road is varied, and implementation differs according to local circumstances. The case studies described in the next section show how three places are putting some of these ideas into practice.



3 How some commissioners are thinking differently: three case studies

This section outlines case studies of three CCGs that are taking a new, more collaborative approach to commissioning. All are working with partners – other CCGs, the local authority and providers – to address local needs and join up services. However, they are focusing on different types of collaboration, taking different approaches, and are at different stages in their development. The CCGs are:

- South Tyneside
- Tameside and Glossop
- Bradford district and Craven.

These three areas are not unique; during our research, we heard from commissioners in other parts of England who are working in this way or applying similar approaches (see summary of roundtable findings in Appendix D). However, there are many parts of the country where commissioning has not adapted to the new, more integrated nature of the NHS; we explore some of the factors that have made the case study areas particularly amenable to change in the individual case studies and in the discussion that follows in Section 4.

There is no single ‘right’ answer to what the role of the commissioner should be in the environment described in Section 2. We present these case studies as examples of different approaches at different stages of development, which we hope other areas can learn from as they develop their own commissioning functions, tailored to local needs and circumstances. For those interested in more contextual information about each case study site, more detail is provided in Appendix B.



Case study 1: South Tyneside

Background

South Tyneside is a small CCG covering a population of around 150,000 just east of Newcastle upon Tyne. It sits within the large North East and North Cumbria Integrated Care System, which extends up to the Scottish border and covers a population of more than 3 million. The area faces a number of health challenges, including life expectancy and some key child health indicators that lag well behind the national average ([Public Health England 2019](#); [South Tyneside Partnership 2017](#)).

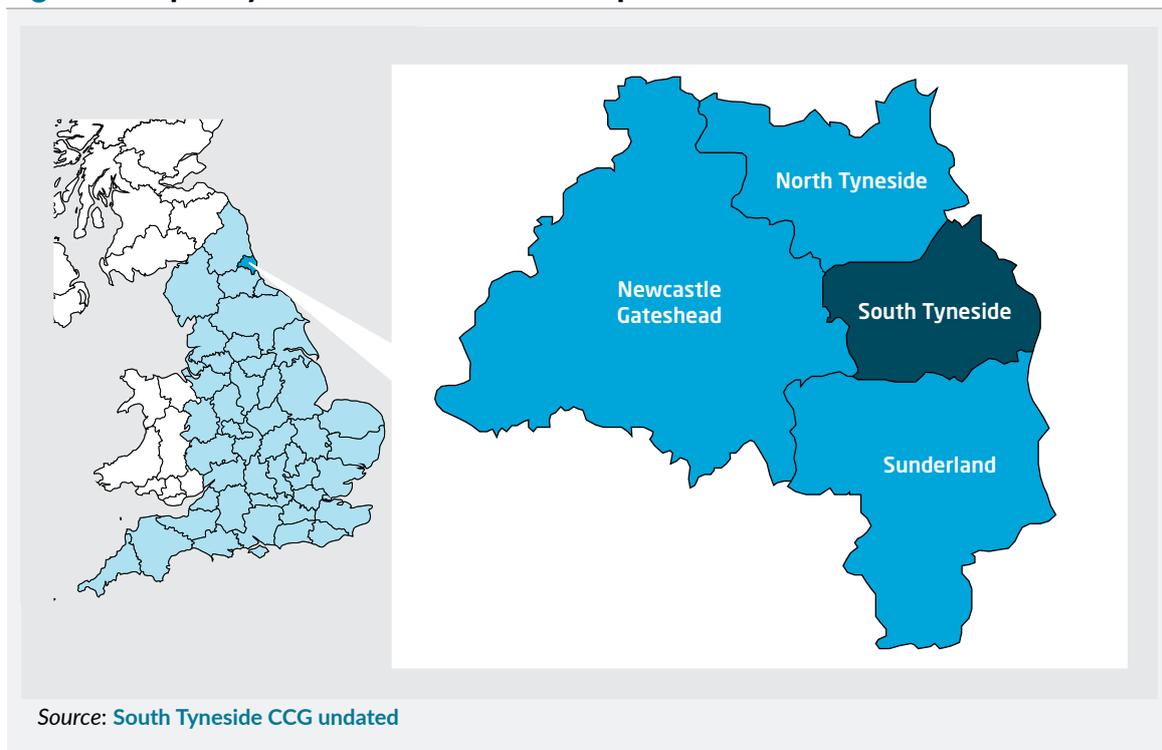
The CCG is a relatively small organisation, with 24 full-time equivalent (FTE) staff, which works closely with NHS North of England Commissioning Support Unit. It is co-terminous with South Tyneside local authority. In 2019, the main acute trust in the area merged with its neighbour to form South Tyneside and Sunderland NHS Foundation Trust. The merger is one part of a major transformation and reconfiguration programme, called Path to Excellence, which both trusts have been undertaking since 2016 with support from local CCGs ([Brown 2019](#); NHS England and NHS Improvement 2019f; [The Path to Excellence 2019](#)).

Another major provider in the area is Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, which provides mental health services to South Tyneside as part of its large footprint across the north of England (see Figure 2).

There is a long history of collaboration between NHS and local authority leaders in South Tyneside. This developed further in 2015, when South Tyneside was partnered with New Zealand's Canterbury District Health Board as part of NHS England's Integrated Care Pioneers programme – a relationship that proved critical to the development of their integrated approach to commissioning, as one interviewee explained.

That was the most powerful thing that has ever happened to us, I think, because we heard their story and they had put into words and action all the things that we were thinking about. So it was just an immediate connection with them and certainly I, personally, said that is what we need to be doing. That is it!

(CCG interviewee)

Figure 2 Map of Tyneside based on CCG footprints

What is the South Tyneside approach?

Inspired by its new partner, and motivated further by a difficult financial situation in its provider trusts, the South Tyneside system started to implement some of the core concepts behind Canterbury's integrated way of working (Charles 2017). These included the following.

- **'One system, one budget'**: getting providers and commissioners to work together in a more open and transparent way to decide how best to spend the 'South Tyneside pound'. This meant shifting individuals' mindsets from protecting the interests of their organisation to promoting the interests of the system.
- **'High trust, low bureaucracy'**: empowering staff to cut through bureaucracy and work in new ways without a complex set of sign-off procedures. We heard a number of examples of this approach operating in practice (eg, see box p 30).



- **No major reorganisation:** Canterbury developed an integrated approach without making major changes to organisational structures. Interviewees told us they felt bruised by the fallout from the 2012 Health and Social Care Act and were therefore particularly attracted to the idea that change was possible without structural upheaval to the system.
- **Health pathways:** South Tyneside implemented a tool developed in Canterbury to map patient pathways. As in Canterbury, the biggest impact from this tool was reported to come from the process of developing it, which involved conversations between GPs and hospital clinicians that helped to create new relationships and break down barriers.

The South Tyneside approach focuses on behaviours rather than structures. Interviewees from both provider and commissioner organisations told us that the commissioner's role had changed from an organisation that 'split' the system apart by using contracts and compliance to promote efficiency, to one that 'glued' it together by linking organisations and promoting collaboration.

So our job as commissioners – as well as still being, you know, the legal fundholders and responsible for several hundred million pounds – is a bit like the glue, the connector. And sometimes it's being able to offer some constructive challenge or a helicopter view.

(CCG interviewee)

To support this, it developed a vision and values for the system based on a population health approach. And, rather than service contracts, it is these values that interviewees told us they fall back on when difficult decisions challenge their new way of working.

How does it affect the way they commission?

Planning

One of the most striking things about our visit to South Tyneside was that leaders from across the system spoke with one voice about their approach. Among the senior managers that we interviewed, it was difficult to tell who worked for which organisation – something one interviewee described experiencing at a recent system event.



And now the person facilitating that was from NECS [the NHS North of England Commissioning Support Unit], and I was chatting to her at the back and she said the thing I notice is I know the CCG, I know there's NECS, I know there's local authority, I know there's trust, but I can't tell you who's who. We didn't gravitate to NECS tables and local authority tables... we gravitated to just a mix, and you could not tell who was who. That is just maximising your available resources.

(Commissioning Support Unit interviewee)

The collaborative approach to planning and decision-making in South Tyneside is called 'alliancing' and has both formal and informal elements. It is underpinned by an Alliance Charter that has been signed by the CCG, the council, two local foundation trusts, and the voluntary sector via their representative network Healthnet. The charter includes a set of principles that guide the way leaders in the system undertake their role. It has a top-line commitment that they will reach consensus decisions on the basis of 'best for the person, best for the system'.

The alliancing approach includes collaborative decision-making structures for deciding local priorities, taking decisions about proposals and leading local change programmes. The Alliance Business Group – a system-wide group that is accountable to the health and wellbeing board – has members from the CCG, the council, local providers, Healthwatch, and voluntary and community sector (VCS) organisations. It oversees integrated working in South Tyneside, including that of the joint commissioning unit, between the council and CCG, which manages around a quarter of the CCG's budget (the rest is managed by the CCG and local authority separately within their own organisations). Local alliances sit beneath the Alliance Business Group and develop work on specific themes.

However, perhaps the most innovative part of their model is also the least formal: the alliance leadership team. This concept – borrowed from Canterbury New Zealand – is the crucible for collaborative working in South Tyneside (see box).



South Tyneside alliance leadership team

The alliance leadership team holds a three-hour meeting that takes place every month with no agenda, no papers, no minutes and no decision-making power. It brings together a range of senior leaders from across the area who have been identified as key influencers (not necessarily those at the top of the hierarchy). The meeting includes perspectives from the CCG, local authority, acute trust, mental health trust, commissioning support unit, voluntary and community sector, local Healthwatch, and primary care networks. It is chaired by the director of public health with support from an independent facilitator, with whom they worked closely initially to establish their ways of working.

Each month around 10–15 people attend the meeting and have discussions based on a broad set of themes. The focus is more on *how* they want to work as a system than *what* they want to do. They identify opportunities to unblock issues, which are then passed on to others for action.

Members of the alliance leadership team spoke enthusiastically about the impact it has had by creating a culture of collaborative working among senior staff. They linked these conversations to real improvements in things like their Continuing Healthcare programme (*see below*).

This new way of working required a significant investment of staff time, took some time to embed and met with scepticism at first. But engagement improved as people started to see tangible benefits from the approach.

The early days of our facilitated discussions on that were hilarious really. Watching people, system leaders, grapple with the tension of... It feels like we're coming together to not really do anything. Not recognising that what we were doing was kind of, forming relationships and understanding what makes each other tick, and understanding, kind of, what it means to do real work.

(Local authority interviewee)

They have plans to establish an alliancing academy to spread this model to staff at other levels of their organisations – creating the right conditions to promote collaboration at the level of middle management.

Procurement

The new approach to commissioning has resulted in the CCG taking a different approach to procurement. It has moved from a transactional approach to one more



centred on relationships and trust, and interviewees told us that procurement is now seen as the route of last resort. Instead, they work with system partners to get agreement about the best way to fulfil a particular service need.

Procurements are probably a method of achieving change of last resort. We find they're often time-consuming, laborious, divisive and not very productive in terms of the outcome that they get. So we deliberately set off on that footing that we will work with our existing people in the system and we will only ever go to market or go to take formal procurement as a last resort. That's sometimes completely at odds with the advice we get from our procurement team. They'll say, 'well, clearly you have to put this out to formal tender, da, da, da'. We go, 'remember our vision and values, what are we going to get for this?' So yes, we've been quite, I think, firm in our approach to that type of issue.

(CCG interviewee)

The area has also changed the way it uses incentives in the system, moving away from rewarding specific tasks and outcomes. This includes implementing a block contract with the main provider, which covers all acute and community care (except for maternity) and has been in place since 2017/18. This has now been extended to include a £5 million risk pool between the foundation trust, the CCG and a neighbouring CCG. Interviewees told us that it was difficult for the provider to initially sell the block contract to their board, but the system had reached a tipping point – the foundation trust realised that its PbR income was not enough to cover costs, and that it needed to fundamentally change its funding approach.

Interviewees from the CCG acknowledged that change takes time but told us that the block contract is starting to change the way the trust works with commissioners. For example, rather than submitting business cases for additional services, they have a system-wide conversation to work out how they can resource it, as a system.

The CCG has also applied its alliancing approach to the local GP incentive scheme and used it as a framework to guide decisions about how to spend non-recurrent funding received from NHS England and NHS Improvement (see box).



Alliancing principles in practice

High-trust, low-bureaucracy approach to local enhanced service (LES) payments

Applying the 'high-trust, low-bureaucracy' principle borrowed from Canterbury, the CCG redesigned its LES incentive scheme in 2018, replacing a set of small individual incentives that provided a few pounds per patient for completing specific tasks with one simple payment. It provided GPs with comparative data on referrals and other aspects of performance and asked them to review the data and complete a piece of quality improvement work during the year. Each practice had to produce a poster at the end of the year to share learning, and the CCG organised a successful GP learning event to facilitate this.

A system-wide approach to allocating non-recurrent funding

At the end of 2018/19, South Tyneside CCG received £2 million of non-recurrent funding from NHS England and NHS Improvement. Rather than deciding as an organisation how to spend the money, it used it as an opportunity to apply its alliancing principles and take a system-wide approach. It asked local alliances (multi-organisation groups on specific themes like mental health, end of life, and frailty) to submit bids for the money, which had to be in line with the alliancing approach. The alliance leadership team reviewed the bids and recommended how the money should be spent. The projects funded included health and wellbeing events to support people with cancer, a mobile needle exchange, and a programme to stop over-medication of people with learning disabilities and autism. Staff involved in the alliance leadership team said the system-wide process led to them investing more in population health-focused projects than would otherwise have been the case.

We aren't going to decide how we spend what is technically CCG allocation, we're going to let people within the system help to make that decision. For me, that is definitely giving something up, but are we going to make better decisions because of it? Well, of course we are! So it feels like it's just the right thing to do.

(CCG interviewee)

Monitoring and evaluation

The CCG has ambitions to create system-wide approaches to monitoring finances, performance and quality throughout the year, but these are still a work in progress.



It does, for example, have quarterly meetings of financial directors from the CCGs and foundation trust to discuss the risk pool, and is working towards producing a single finance and performance report for the system and setting up a shared project office to deliver the financial recovery plan. The aim is for the contract to take a back seat in these system-wide conversations.

It has been able to get rid of some of the CCG monitoring meetings.

One meeting that has gone, we had a contract operational group (the COG), which pored over activity and finance data with all the providers, the hospital providers... and looked for, sort of, you know, challenges, hotspots, pressures (as they were called). We don't do that anymore, so that meeting has gone. And partly because the hospitals are on block contract, but also because we realised that we were having these conversations, commissioners-only conversations about why dermatology outpatient procedures seemed to have skyrocketed.

(CCG interviewee)

In the future, the CCG would also like to slim down its quality and safety committee, establishing a system-wide quality review group.

The current processes require a lot of double running – for example, the CCG still has to collect all of the data necessary for an activity-based system running PbR because this has to be submitted to national NHS bodies.

Staffing and skills

The new approach has both attracted new staff to the system and prompted some to leave because they did not like aspects of the new ways of working, such as the new approaches to procurement and incentives. The biggest role changes have been in the procurement and contracting teams of both the CCG and the main trust.

I've got a whole [XXX] team that are used to going to contract meetings and chasing this and doing that and now their focus is a bit... is different. But that's been a process that we've had to go through to sort of try and sell that to the teams and get their engagement. Because people are obviously quite protective of their roles and they come in on a Monday and they know what the job is and all of a sudden you kick their legs out from under and go, 'no, we don't want you to do that anymore.'

(Provider interviewee)



One interviewee told us that the focus of their team's work was now more on transformation than contract management. This has required staff to be flexible, as their day-to-day work changes – for example, having conversations with clinicians about pathways rather than finance representatives about contracts. There has also been a learning curve for NHS commissioning staff who have been working with the local authority through the joint commissioning unit. They have had to adapt to working with local councillors and the public in a more political environment.

Leaders in the NHS and local authority are also starting to take a system-wide approach to recruitment – for example, holding back vacancies until they know what resource the system needs.

What are the benefits of this approach?

The CCG links its alliance way of working to improvements in decision-making and the conversations that are had as a system (*see box*), as well as in the design of services.

Commissioners told us about more transparent conversations where providers were more open about issues they were experiencing, enabling the system to find solutions.

When I was in other areas, I had providers who would hide when they were having problems with staffing and that side of things. Now they would come... I mean, we have had providers from both our NHS and private going, 'actually we're really struggling on this, can we look at some solutions?'

(Local authority interviewee)

Interviewees also highlighted a number of service design changes that were benefiting patients. For example, the CCG recently introduced a new trusted assessor model into its Continuing Healthcare programme whereby district nurses, social workers and palliative care teams are empowered to decide what package of care people need, rather than going through lengthy application processes with multiple commissioners. As a result, they reduced the number of fast-track packages (for those requiring quick access due to deteriorating health) by more than half, and standard packages by around two-thirds between the first quarter of 2017/18 and the second quarter of 2019/20 ([NHS England 2019b](#)).



The quicker, easier process means that staff feel empowered to give patients the package of care they need now, rather than trying to predict future needs and apply for a more extensive package – which some did in the past due to worries about the length of time it took to get the packages approved.

The CCG has also linked its approach to reductions in delayed transfers of care and smoking during pregnancy, as well as improvements in mental health service standards (NHS Clinical Commissioners 2019; South Tyneside CCG 2019b).

How did they make it happen and what are the ongoing challenges?

Change was possible in South Tyneside in part because of its history. Leaders of the main NHS and local authority organisations have long-established strong relationships as well as a shared vision for a more collaborative approach. The Canterbury system in New Zealand provided inspiration and some core concepts and tools to help embed the new way of working. The CCG also received a small amount of financial support from the Integrated Care Pioneers programme (which paid for the initial external facilitation of the alliance leadership team).

Role-modelling by senior leaders has been important: leaders described having to be brave and to move beyond their individual concerns and egos.

Provider engagement in the new approach was also partly motivated by a financial burning platform.

The two trusts were bankrupt; we didn't have enough money coming in to deliver the services we needed to, so we couldn't carry on just throwing more money at it. And the money just didn't exist in the system so we had to do something separately, something differently anyway.

(Provider interviewee)

Undeniably important is the strong sense of local identity in South Tyneside, which is furthered by low staff turnover (compared with some other parts of the country) and the fairly 'closed' nature of the system.

Its stable performance has also, according to CCG interviewees, enabled it to stay under the radar to some extent and, they felt, avoid intervention from national



NHS bodies that might have scuppered reform. They also, however, highlighted the challenge of working with regulators who are focused on organisations instead of systems.

There continue to be challenges in working in this new way. The approach requires a large time commitment, and for providers such as the mental health trust, which works over a much larger geography with multiple commissioners, it is hard to find the capacity to engage in the alliancing approach (although it was impressive to hear that the trust was engaging despite these difficulties). Providers also found it challenging working with multiple CCGs with different approaches.

We heard that the emergent approach in South Tyneside meant that new initiatives tended to spring up all over the place, and could feel unco-ordinated at times. The CCG was trying to address this by organising system-wide events to share information about what they were doing and learning.

The system-wide monitoring structures were still underdeveloped, and some interviewees raised the potential for blind spots in a high-trust, low-bureaucracy system (although others pointed out there were blind spots in low-trust, high-bureaucracy systems already). They also acknowledged the risk that initiatives like South Tyneside's reformed LES payments (*see box*) could widen inequalities if already poor-performing providers did not respond to the incentive.

Although VCS engagement was recently highlighted by the Local Government Association as a strength of the system as part of its peer review, interviewees told us that fully integrating the sector into their approach was a work in progress ([Local Government Association 2018b](#)).

Where are they heading next?

Interviewees outlined two key priorities for further developing their approach. The first is to cascade the collaborative ways of working further down the constituent organisations in their system. The current approach is dependent on some key individuals in the system who lead and role-model the ways of working. We heard that while executive-level and senior leaders were fully on board, and there was some trickle-down effect on frontline staff – who were starting to use the language of 'alliancing' when describing their work – there was still some way to go to fully



embed the approach among middle managers and beyond. Further embedding the approach will reduce its dependence on key individuals and the risk of reverting to old behaviours if those people leave.

I'll use the lemon drizzle cake analogy. You know, in some places the drizzle has gone right down to the bottom and... in some places it's just an inch deep... there's a bit more to go... I think the acid test is, you know, it will be when the drizzle is nice and evenly deeply spread throughout the cake...

(CCG interviewee)

There is also work to be done to remove duplication in the system whereby organisational processes are running alongside the new system structures. In some cases, it is not clear whether it will be possible to stop the double running because of requirements from national NHS bodies and the statutory powers of the individual organisations.

Interviewees told us that the system has focused in the first instance on changing behaviours, which means that work on formal governance to codify the new approach is some way behind. This was also noted in a recent peer review of the system conducted by the Local Government Association ([Local Government Association 2018b](#)). South Tyneside is seeking to learn from other areas that have developed their structures further, including our next case study – Tameside and Glossop.

Key learning from the South Tyneside approach

- Change is not always driven by the introduction of new formal structures. It was the least formal part of South Tyneside's decision-making model (the alliance leadership team) that acted as one of the most powerful drivers of collaborative working and culture change across their system.
- Concrete actions that demonstrate senior-level commitment to collaboration are key to building credibility and buy-in across the system. In South Tyneside, the redesign of the GP incentive scheme and decision to use alliancing principles to allocate the £2 million non-recurrent funding boost were important markers of the senior leadership's commitment to their approach and helped garner support from staff across their system.



- The key shift in mindset required for the new approach was from the interests of individual organisations to the interests of patients and residents, and therefore the system as a whole.

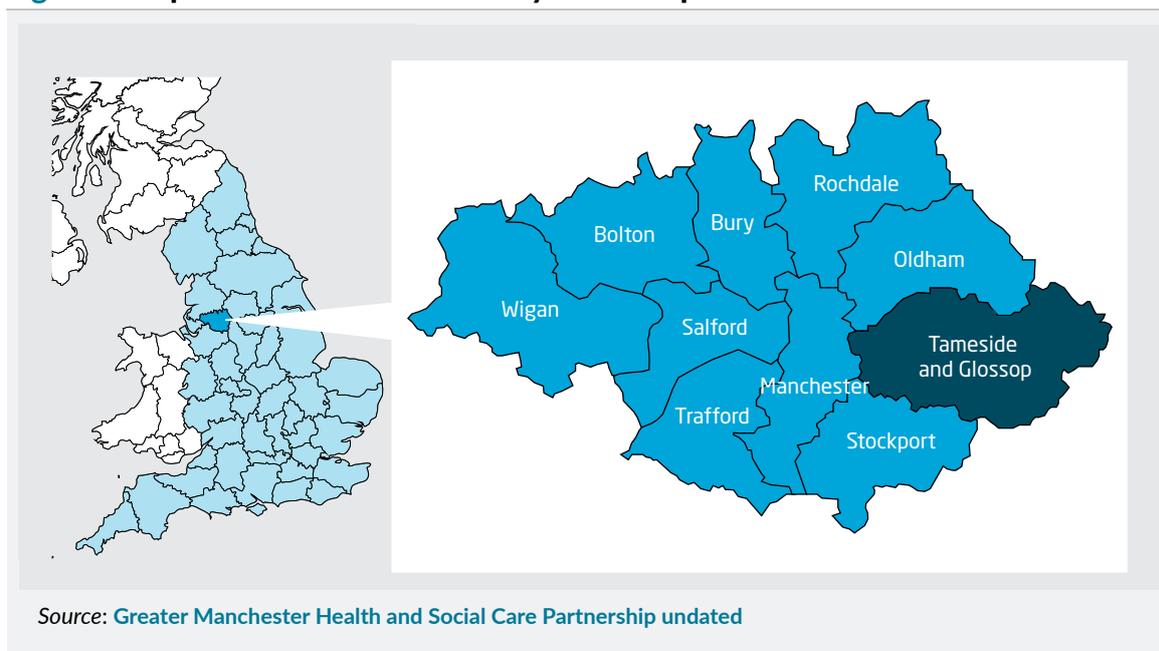
Case study 2: Tameside and Glossop

Background

Tameside is a metropolitan borough on the eastern side of Greater Manchester, which borders the Peak District to the east where Glossop is a market town (see Figure 3). Tameside and Glossop CCG has covered both areas since its inception (as did its predecessor, the PCT). The footprint includes a mix of urban areas, largely in Tameside, and more rural parts in Glossop.

The CCG covers a population of around 255,000 (of which Glossop residents make up approximately 15 per cent). A number of key indicators of population health in Tameside and Glossop are below the average for England, influenced in part by relatively high levels of deprivation and poverty. Overall life expectancy and healthy

Figure 3 Map of Greater Manchester by CCG footprints





life expectancy for men and women is below the average for England and for the North West of England ([Tameside Metropolitan Borough Council et al 2017](#)).

The CCG is in large part co-terminous with Tameside Council; Glossop sits in Derbyshire where Derbyshire County Council is the upper-tier council, and High Peak District Council the lower tier. The key local NHS acute and community provider is Tameside and Glossop Integrated Care NHS Foundation Trust, which until 2016 was known as Tameside Hospital NHS Foundation Trust (discussed further below). Mental health services in the area are mostly provided by Pennine Care NHS Foundation Trust.

Tameside and Glossop sits within the Greater Manchester STP footprint, which agreed a devolution deal with the government and national NHS bodies in 2015. Although strictly closer to delegation, the devolution deal came with around £450 million in transformation funding over a five-year period (2016/17 to 2020/21) ([Walshe et al 2018](#)).

What is the Tameside and Glossop approach to commissioning?

Tameside and Glossop's approach to commissioning focuses on population health, based on a fully integrated organisational and governance structure across the CCG and Tameside Council. This arrangement is supported by strong collaboration between commissioners and the main NHS provider in the area.

Five years ago, the Tameside and Glossop health economy was facing serious challenges. The key provider – at that time, the Tameside Hospital Foundation Trust – was part of the Keogh review due to high mortality rates and was subsequently put into special measures by the Care Quality Commission (CQC). Simultaneously, commissioners were under significant financial pressure, with the council managing the impact of large budget cuts. Overall, the local health economy was facing a deficit of £70 million by 2020/21 in a 'do-nothing' scenario. Interviewees told us there was a 'burning platform'.

With the support of some external, centrally commissioned consultancy, the key stakeholders in the system responded by coming together to reflect and develop a vision for the local system covering the full range of health and care services. Front and centre of that was reforming the commissioning functions in the borough to



create a single place-based commissioner for health, social care and other public services in Tameside.

Since then, the council and CCG have been operationalising this vision by creating a new organisation – the Tameside and Glossop Strategic Commission – which delivers the functions of both bodies, spanning health and care and the wider functions of the local authority, including children’s services, education, transport, leisure services, and local economic development. A joint chief executive/ accountable officer was appointed in 2016 (initially interim, now substantive). A joint finance officer followed in 2017. Today the two organisations – although they still exist legally – are fully combined, with a single way of working and a single leadership team spanning all their functions. In 2019 the two organisations moved into co-located office space.

Alongside these changes to the organisation of commissioning – and central to the overall project – was a change in mindset in favour of a population health approach. Where before, its focus had been on commissioning effective health and care services, now its field of vision extends across the full spectrum of local public services, aiming to exert the most positive impact possible on Tameside and Glossop, the place, through all available levers. As a senior leader described it to us.

There is a fundamental decision that sits at the heart of that: are you commissioning to want to get a better health and care system, or are you locating the health and care system within a place, and are you commissioning for better outcomes for place?

(Strategic Commission interviewee)

This ambition was codified in a locality plan, published in 2015, which set an overarching goal of raising healthy life expectancy in Tameside and Glossop to the average for the North West of England by 2020 – an increase of more than three years for both men and women ([Tameside Metropolitan Borough Council et al 2015](#)).

These changes to commissioning arrangements sat within a wider programme covering the whole Tameside and Glossop health economy. Tameside Hospital NHS Foundation Trust’s role was reimagined to become an integrated care organisation (ICO) delivering a wider portfolio of acute, community and eventually social care



services and interfacing more seamlessly with primary care in the borough. In 2016, Tameside Hospital NHS Foundation Trust took on responsibility for providing community services for the borough, which had previously been delivered by Stockport NHS Foundation Trust, and rebranded to become Tameside and Glossop Integrated Care NHS Foundation Trust. Throughout, it has been a vital partner in the change process (explored further below).

How does this affect the way they commission services?

Planning

Key to creating a single commissioner for the borough was establishing a single joint decision-making forum covering the full spectrum of council-funded and CCG-funded services. Today, a strategic commissioning board (SCB) sits at the apex of the decision-making structure in Tameside and Glossop – exercising powers delegated from the council and CCG. It provides leadership for delivering the locality plan, oversees the management of pooled funding arrangements (discussed below), provides oversight and assurance of key providers, and leads the further development of the commissioning function.

Chaired by one of the CCG's clinical co-chairs, the SCB's membership includes the clinical, political and managerial leaders from both organisations (the trust is not a member). Key executive members of the council (eg, the leader, member for adult services and member for children's services) sit alongside the CCG GP governing body members, ensuring an approximate balance between clinical and political membership. The joint council/CCG accountable officer is also a member. Representatives from Derbyshire County Council and High Peak District Council are entitled to attend. The SCB meets approximately monthly in public and operates, wherever possible, by consensus (although there is an agreed voting procedure: one-member-one-vote, with the chair holding a casting second vote if needed).

Interviewees told us this synthesis of different perspectives at the key decision-making point was crucial to Tameside and Glossop's approach. They reported that it enabled more transparent conversations about resource allocation, and brings into focus the interdependencies in the health and care system. Crucially, it also created a place where different perspectives on issues could be discussed and reconciled – rather than senior decision-makers participating in different decision-making structures resulting in conflicting signals. The SCB has mostly been able to reach



agreed positions on key commissioning decisions; so far, a decision has only once gone to a vote.

Today, both long-term and short-term planning processes flow through the SCB. For example, it oversaw the development of a new corporate plan for the Tameside and Glossop Strategic Commission. This articulated a number of key themes the system would focus on between 2018 and 2025 (discussed further below). Similarly, it leads the annual prioritisation process, with the commission issuing one set of commissioning intentions to all of its providers each year.

These changes to the formal planning structures have been allied with more informal methods of translating planning priorities into operational change. Senior leaders in Tameside and Glossop have established forums outside formal governance structures where they come together – commissioners and providers – to discuss strategic direction and operational issues. For example, a monthly leadership executive group meeting operates as an informal place for senior leaders from both the commission and Tameside and Glossop Integrated Care NHS Foundation Trust to tackle ‘wicked issues’.

Procurement

To enable joint decision-making across the full spectrum of services, the commission has re-engineered its financial arrangements. From 2016/17, it has operated a pooled commissioning fund known as the Integrated Commissioning Fund (ICF), which has gradually grown over time. Today, the ICF encompasses both organisations’ total budgets and is worth around £950 million in 2019/20 (see box). The ICF is underpinned by a risk-sharing agreement, which allocates risk for overspends in approximate proportion to the council and CCG’s ICF contributions: one-third council, two-thirds CCG.

The commission has also simplified its financial arrangements with its key provider of acute and community services – Tameside and Glossop Integrated Care NHS Foundation Trust. A block contract has been in place since 2017/18, which includes an outcomes component. In 2019/20, for example, £1 million of reimbursement is linked to the trust delivering against a jointly agreed set of outcomes (eg, increasing the number of people dying in their place of choice) ([Ramachandra et al 2019](#)).



Integrated Commissioning Fund

The Tameside and Glossop Strategic Commission has created a single Integrated Commissioning Fund (ICF) by pooling the total resource of the council and CCG. To satisfy the legal requirements on different elements of funding, the ICF is separated into three components (known as pots) with slightly different decision-making arrangements (Roe 2019).

- **Section 75** includes the bulk of the ICF – approximately 50 per cent – and over this resource, the SCB can make decisions that are binding on the CCG and council.
- **Aligned services** cover those elements of funding that cannot be included in a Section 75 agreement – around 40 per cent – and the SCB makes recommendations, which are ratified by the constituent organisations (examples include some elements of acute care such as surgery and radiotherapy, and children’s services).
- **In-collaboration services** include funding – approximately 10 per cent – which has been delegated from national NHS bodies (eg, funds for primary care commissioning and the schools grant). The SCB makes recommendations, which are remitted to the CCG and relevant national body for decision-making.

On decisions relevant to aligned services and in collaboration services, the council executive cabinet and CCG governing body are key decision-making forums. Derbyshire County Council does not participate in the pooled funding arrangements.

Monitoring and evaluation

Monitoring of financial performance has been brought together under the auspices of the Strategic Commission. Since 2018/19, the commission has monitored and reported financial performance across the local health system – CCG, council and the Integrated Care NHS Foundation Trust – in one place. Board papers to the SCB report the system-wide position, including identifying service areas that are experiencing financial pressure and showing delivery against cost improvement plans. This ensures that the SCB’s deliberations can be informed by an accurate understanding of the system-wide financial position (Roe and Simpson 2019).

The performance management relationship with the Integrated Care NHS Foundation Trust is evolving as well. The commission is reducing its reliance on



extensive lists of key performance indicators when commissioning new services. Instead, it is cultivating a culture of openness with providers and empowering commissioners to exercise their professional judgement in performance monitoring. Interviewees spoke of this as a change of mindset about how commissioners manage relationships with providers.

I'm not going to order our partners or our commissions to do x, y, z if they've got issues with something over there. I'm going to try and help them sort out those issues...

(Strategic Commission interviewee)

Similarly, to support the seamless management of contractual business, the commission and trust have formed an integrated contracting function.

The commission is increasingly looking to monitor performance against a set of high-level population objectives. A recently developed corporate plan identifies a group of high-level priorities – for example, 'longer, healthier lives' with associated metrics, which will be the basis for tracking the extent to which the system is positively affecting residents' lives.

Staffing and skills

Staff roles in Tameside and Glossop have seen substantial change in recent years. A number of teams have been brought together (for example, an integrated intelligence function reporting across health and social care and the integrated contracting team). This enables formal, structured collaboration and, in addition, we heard that it enables spontaneous, informal sharing of intelligence among commissioners. As one commission interviewee summarised it, 'nothing beats being in the same room'. While interviewees emphasised the benefits of this way of working, they also acknowledged that it has entailed substantial change for team members – and that at times, people have found the change process challenging. Senior leaders spoke of the ongoing task of balancing pace of change with staff sentiment and behaviours.

Commissioners also told us that their personal skill-sets are being developed through this way of working. Increasingly, they explained, they need to ally traditional commissioners' skills with more intangible, interpersonal skills. For example, relationship-building and facilitation were highlighted as vital skills when working with providers to design new services. 'Build it, don't buy it' was a shorthand some commission interviewees used to describe this mindset. Crucially,



this means both staff working in different ways, and doing different things, as a senior commissioner explained.

What I now think about is far less about pathways and telling providers how to provide, because I think those days are long gone... I think much more about the wider public sector stuff. So most of my thinking now is around how do we get our children school ready? How do we keep our elderly people resilient and happy at home?

(Strategic Commission interviewee)

Organisational culture has been a key focus for the commission over the past few years. Recognising that the two groups of staff come from bodies with different traditions, senior leaders have spent time (for example, through awaydays and social events) on fostering a distinctive ethos for the Strategic Commission. Today, according to interviewees, staff largely identify with the commission rather than their previous employers.

Non-executives were also cited as playing an important enabling role. Interviewees highlighted that Tameside and Glossop's way of working makes different demands on senior leadership teams among the participating organisations. In turn, non-executives' skills need to reflect the broader population health agenda to provide effective oversight and challenge. For example, Tameside and Glossop Integrated Care NHS Foundation Trust has been gradually diversifying the skill-set of its non-executive directors, bringing in some individuals with expertise in the voluntary, community and social enterprise (VCSE) sector and housing associations.

What are the benefits of this approach?

We heard about a number of benefits of this way of working. On an actuarial level, coming together has allowed the commission to save on running costs (meeting the 20 per cent running cost reduction mandated by NHS England). A single senior leadership team, shared teams and co-location of offices have all supported a lean operation.

More fundamentally, interviewees talked about the SCB having different conversations about its commissioning plans, partly because of elected councillors bringing a different perspective to those discussions. Some interviewees spoke



of how councillors bring a constructive challenge into the room – for example, in relation to mental health services. Councillors acknowledged that this role can be stretching for them (although they were clear it is the right thing to do) because they are contributing to decisions across a broad portfolio of services, including health care services, which would previously have been the remit of the CCG.

Interviewees explained that involving councillors – contrary to what some people may expect – helped in delivering service change. For example, Tameside and Glossop recently reconfigured intermediate care beds, and interviewees spoke about how that project had the potential to be politically difficult. However, by involving councillors in the process and supporting them to understand the case for change and shape the choices, the project was made more, rather than less, deliverable. Some senior leaders admitted that the positive input of councillors has been a revelation to them.

When I think back over my many, many years in the health services... I've never quite realised how important councils and councillors could be... It's your local councillors and working much [more] closely with them and establishing relationships with the councillors.

(Strategic Commission interviewee)

Bringing together the capabilities of the CCG and council has also opened up possibilities that a CCG acting alone would find practically difficult. For example, the installation of digital tools at some care homes in Tameside and Glossop required construction work to lay cables to ensure sufficient internet speed. The commission was able to make that happen thanks to the council's purview over roads. Subsequently, the commission is seeing signs that this is having a positive impact on numbers of ambulance call-outs to care homes.

How did they make it happen and what are the ongoing challenges?

Interviewees pointed to a number of factors enabling Tameside and Glossop to make change.

First, the approximate co-terminosity of the council and CCG footprints was cited as an enabler because it created a basis for a shared conversation between senior leaders about how to work together. Relatedly, being part of Greater Manchester



was thought to be a net enabler; the STP was supportive of Tameside and Glossop's direction of travel and provided transformation funding of around £23 million over three years to facilitate change projects. This funding supported some discrete operational initiatives such as the introduction of some digital health tools.

Leadership style was singled out by interviewees in two respects. First, we heard how important it is for leaders to have a clear vision for the system and to be able to articulate that in a way that resonates with staff. Staff need to be 'emotionally attached to the journey', as one Strategic Commission interviewee put it. Second, interviewees spoke of a leadership style that is willing to take calculated risks, is pragmatic regarding managing conflicts of interest, and is ready to offer constructive challenge to national NHS bodies. Interviewees felt that both types of leadership style were present in Tameside and Glossop.

Relationships were regularly highlighted as a crucial enabler of the change process. In particular, interviewees spoke about how the relationship between the Strategic Commission and the key provider – Tameside and Glossop Integrated Care NHS Foundation Trust – had previously been quite distant but was now transformed. Senior leaders have invested substantial time in understanding the demands – operational and regulatory – on each other and in building that relationship.

Challenges came in different forms. Early in the process there was an attitudinal challenge to overcome: many local clinicians were sceptical about investing in Tameside Hospital because, as one interviewee explained, it 'didn't have a good reputation'. On an ongoing basis, some interviewees highlighted the legal, regulatory impediments that hinder the creation of a single commissioning organisation. Strategic Commission staff, for example, remain on a combination of NHS and council contracts. National policy initiatives can also sometimes create local challenges. The introduction of primary care networks was an example where national guidance was partly at odds with the approach that had been developed locally.

Interviewees also spoke about how the national structure of the NHS can push against the behaviours they are trying to cultivate.



The system context... it's continually pulling you the other way. It fragments, it doesn't encourage collaboration, it encourages conflict, encourages adversarial positions, it encourages blame.

(Strategic Commission interviewee)

For leaders, it takes an ongoing effort to assert their values and behaviours to ensure that those external pressures are kept at bay. Moreover, the financial environment remains extremely challenging. The health and care system in Tameside and Glossop continues to face real demand pressures, particularly in children's services and Continuing Healthcare, so there is an ongoing need to deliver cost improvements.

Where are they heading next?

In Tameside and Glossop, the direction of travel is broadly set. The overarching challenge now is to push forward with implementing the place-based ethos of public sector reform to bring services together to deliver the most positive impact possible. Broadening the agenda from health and care to improve residents' lives as much as possible is the next frontier.

To enable that, there is an ongoing programme of operational change for the provider focused on it playing a larger role in providing adult social care services and mental health services. At the same time, the Strategic Commission plans to further refine its way of working. Engaging with local GP practices to manage the implementation of primary care networks – ensuring that they dovetail with local multidisciplinary neighbourhood teams and interface effectively with the Integrated Care NHS Foundation Trust – is a near-term priority. The commission and the trust plan to evolve their contractual relationship so that a greater percentage of the trust's reimbursement is linked to the delivery of key outcomes. Designing the detail of that mechanism is a work in progress.

Alongside this, the commission is seeking to further embed its population health focus by reorganising its planning functions around a life-course model. It is establishing three thematic boards focused on starting well, living well, and ageing well. The boards – each with a designated GP, councillor, population health and managerial lead – will look across all local public services, identify priorities for the system, develop work programmes, and oversee delivery, with thematic teams



working to each board. This will help the SCB to focus on providing strategic leadership, making macro resource allocation decisions and monitoring system performance.

Key learning from the Tameside and Glossop approach

- It is possible to integrate decision-making and financial arrangements for health, care and wider public services within current legal structures. Although some administrative workarounds are involved, Tameside and Glossop has been able to establish both its Strategic Commissioning Board and Integrated Commissioning Fund within existing legislation.
- Elected local councillors can bring a different and valuable perspective to health and care commissioning. In Tameside and Glossop, councillors have made a valuable contribution to service design that has enabled service change – for example, by bringing insights from their constituents into decision-making.
- By organising planning around different stages of the life course, Tameside and Glossop is starting to shift the focus from health care to population health. This model – which is being adopted across Greater Manchester – offers one example of how local systems can translate a population health approach into practice.

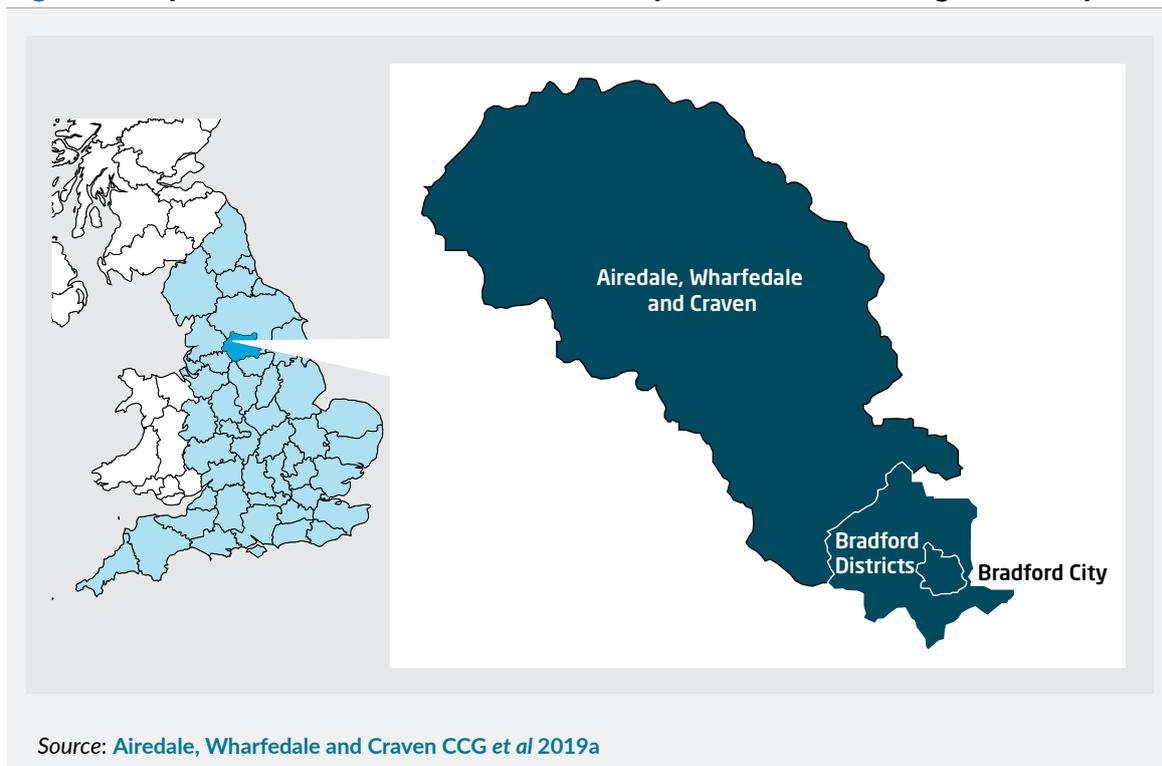
Case study 3: Bradford district and Craven

Background

The Bradford district and Craven area covers three CCGs: Bradford City; Bradford Districts; and Airedale, Wharfedale and Craven. In April 2020 these three organisations will merge to form Bradford district and Craven CCG, with a resident population of just over 600,000. Their footprint includes a young, urban, ethnically diverse and relatively deprived population in and around Bradford and an older, less diverse, more affluent population in rural areas.

The CCGs form one of six ‘places’ within the West Yorkshire and Harrogate Health and Care Partnership Integrated Care System. There are two main acute and community providers in the area: Bradford Teaching Hospitals NHS Foundation Trust and Airedale NHS Foundation Trust; the main mental health trust is Bradford

Figure 4 Map of Bradford district and Craven footprint based on existing CCG footprints



District Care NHS Foundation Trust. The CCGs span three different councils (see Appendix B).

Bradford district and Craven's plan for the development of local services, called Happy, Healthy and at Home, was developed following a 'big conversation' with local residents ([Bradford City CCG et al 2017](#)).

The three organisations provide an example of CCGs that have a vision for how the role of commissioning needs to change in their system, and they are at an early stage in starting to use that vision to change the way they work. They are very open about the challenges involved in doing this, particularly in the current difficult financial context.

What is the Bradford district and Craven approach?

Bradford district and Craven CCGs have a clear vision for their changing role in the local system. This is that their core function is as a system facilitator, using their



resource to enable collaboration rather than provoke competition. Interviewees told us that commissioners have focused on using their power to say ‘no’ for too long, and that they want to focus on using their power to say ‘yes’.

Behaviours and relationships are central to their approach, which uses conversations rather than contracts to define and implement local priorities. This means that the emphasis of their work is starting to shift from the procurement part of the commissioning cycle (which they want to ‘de-power’) to the strategy and needs assessment section. As part of this shift, service development and performance and financial monitoring are starting to happen collaboratively across the system rather than in silos.

The CCGs see their population-focused view of local issues as critical to encouraging system-wide thinking.

They [colleagues] felt collectively that our offer to the system, as a partner, so not as a transactor of something, but our offer to the system was very much around that... we’ve got the population-eye view. Nobody else has a population-eye view. Everybody else has a patient-eye view, or a service user-eye view, because that’s who they’re dealing with. We do have the population-eye view, and that’s our most important offer to the system.

(CCG interviewee)

How does this affect the way they commission?

Planning

Planning decisions in Bradford district and Craven happen through system-wide partnership arrangements between providers and commissioners in the NHS, rather than through CCG-only structures.

The collaborative approach to decision-making was established by an alliance agreement that was originally signed by the two Bradford CCGs and the Bradford Provider Alliance in 2017. The provider alliance is made up of the local acute, community and mental health providers, the local GP federations and the Bradford VCS alliance. More recently, this way of working has been extended to cover the Bradford district and Craven footprint through an extended strategic partnership

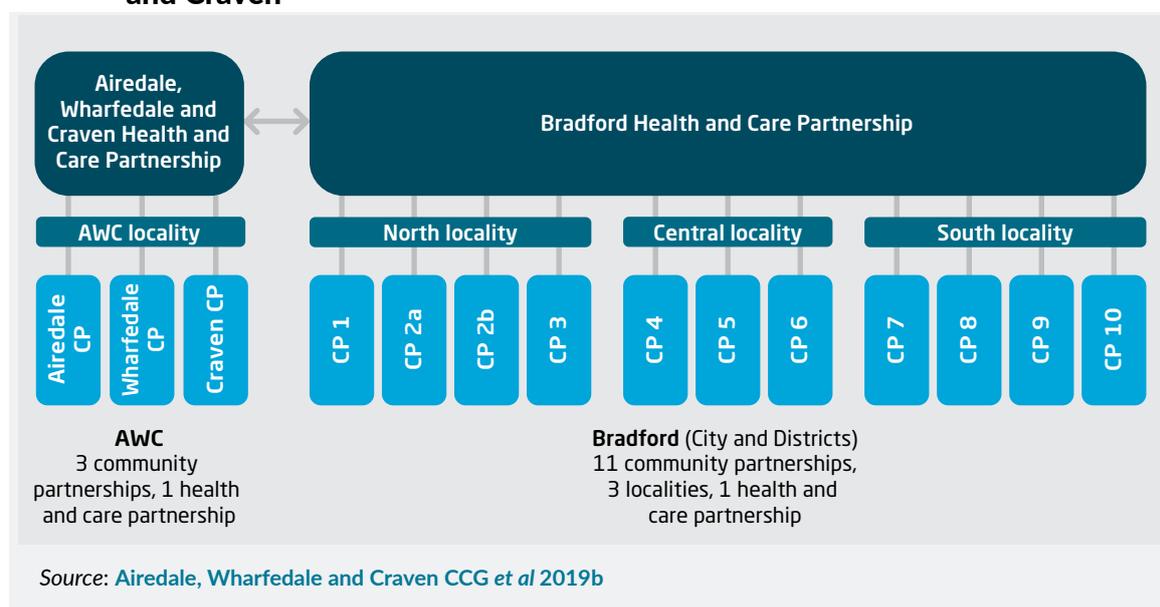


agreement (Airedale, Wharfedale and Craven CCG *et al* 2019b). The independent care sector alliance is now also involved in the alliance.

The existence of an alliance between VCS providers has helped the system effectively engage with the sector – something that other areas have struggled to do. The CQC’s system review of Bradford conducted in 2018 highlighted the VCS as engaged in system working and a valued part of the system (Care Quality Commission 2018).

Planning happens through two partnerships (Airedale, Wharfedale and Craven, and Bradford), which each make decisions for their part of the place, while operational delivery is organised around 14 smaller community partnerships across four localities (see Figure 5).

Figure 5 Place-based planning and delivery arrangements in Bradford district and Craven



The strategic partnership agreement outlines how the partnerships will make decisions, thereby codifying expectations. Its key principles include that decisions should be made at the most local level possible and be transparent, and that the system will make decisions in a collaborative way based on consensus decision-making, rather than a voting system.



Decision-making and decision-taking in Bradford district and Craven

Interviewees from across the Bradford system told us that they used the concept of ‘decision-making and taking’ to guide the way they worked together. Providers and commissioners collectively ‘make’ decisions through the partnership boards and other joint decision-making groups. They then return to their constituent organisations to ‘take’ the decisions formally in line with their statutory powers and functions.

... That’s a total partnership model for commissioning... The providers still do the providing and the commissioners still put their money into this pot locally, but the activities of deciding what it is you’re going to do, and where you’re going to do it, is done in a total partnership.

(CCG interviewee)

It was this concept rather than the detail of the formal structures that seemed to engage and motivate the staff we interviewed to work in a collaborative way.

These formal structures and agreements are unpinned by the concept of ‘decision-making and decision-taking’ (see box), which describes how the different organisations in Bradford balance collaboration with their statutory duties and functions.

Procurement

The partnership approach in Bradford district and Craven is changing the way the area procures services. One interviewee told us how procurement systems have moved on from the ‘old way’ of working.

In the old way the CCG would have developed some specification, some KPIs [key performance indicators], and put it for procurement. In the new way of working we had all the partners at the table, we look at the data together, we look at what are the issues with the Bradford system. What are the needs of the Bradford population? And tried to come up to a combined, jointly agreeable set of specifications and performance indicators... and how the providers together can answer that. Because that is the basic theme of doing this, is that we do not procure... we do not commission the parts of the system, we commission it as a whole.

(CCG interviewee)



In 2019/2020, Bradford district and Craven agreed fixed-income contracts with its two main acute providers through what the commissioner described as a non-adversarial, collaborative contract discussion, rather than a negotiation. This happened through a discussion with the three trusts together, rather than three separate bilateral discussions. However, getting agreement for a fixed-income contract was not easy and tested their consensus decision-making approach.

So there's a bit of a push across the leadership team that this is the right thing to do. So it wasn't easy and it sounds as if we just decided to do it. Well, no, we didn't; 12 months ago we couldn't get to the point where we could agree what a contract would look like to manage everybody's risk. This year [2019/2020] we have. I sometimes think from, kind of, my experience in the NHS, you've sometimes got to go through a dance to get to places. People have to warm up, don't they?
(CCG interviewee)

Bradford district and Craven agreed a set of principles that underpin the contracts and describe what the partners will do if (for example) activity goes above or below expected levels, or there is disagreement on approach.

The more collaborative approach is exemplified in changes to the contract such as the removal of all penalties, other than the 52-week wait penalty, which is enforced nationally.

Within the fixed-income contracts we've removed penalties. So we no longer have penalties on our contract. The only one is the national 52-week penalty, which is enforced at a national level... And we've said, 'no, we're not having those'. That's not... we're not... working in that culture anymore. We're changing the way we're working. And, actually... that allows you to have a different conversation as well.
(CCG interviewee)

The challenges continue, as tight budgets mean that agreeing a fixed amount for next year is also difficult. However, those involved are now able to have open conversations about this as a system, and hope that transparency and their agreed partnership approach will guide them through difficult conversations.



Monitoring and evaluation

The new fixed-income contracts have supported the development of more transparent, system-wide approaches to monitoring finances and performance throughout the year.

The CCGs and local providers have established a system-wide finance and performance committee that started operating in April 2019. Led and chaired by the finance director of one of the acute trusts, the committee involves around 20 people from across the system, including the finance directors, deputy finance directors and chief operating officers from the local trusts and the CCGs. They are working towards the development of a system-wide performance dashboard, though there are challenges in doing so because of different reporting approaches within each organisation.

The new way of working means they have been able to strip out some aspects of the usual pattern of contract management – for example, the CCG no longer undertakes a monthly reconciliation.

... usually what would happen under PbR, you'd do a reconciliation at the end of every month, you'd then go back to the provider and you challenge them on what... they put through if you disagree with it. All of that has stopped because we're not going to challenge them, we're not going to disagree with it... We're equal partners in this. It impacts on them as much as it impacts on us if they're... putting too much through and they're not coding it appropriately.

(CCG interviewee)

They have also established a system-wide committee for quality assurance, which is at an earlier stage in its development. Quality monitoring is now more transparent: for example, one interviewee told us that the trust now shares its quality assurance meeting papers with the CCG in advance, rather than the CCG having to download them from the internet weeks or months after the fact.

The CCGs' relationship with providers in relation to quality is also changing. For example, the CCG quality monitoring team are spending more time in the mental health trust – supporting the organisation's own quality assurance and improvement initiatives.



Staffing and skills

One of the biggest changes in Bradford district and Craven has been to some staff roles, particularly within the CCGs. We heard that within the CCG finance team, for example, there are various mandatory duties that remained the same (like paying invoices, producing accounts and running reports for NHS England), yet there are also now transformational elements to the team's work, which are undertaken collaboratively with providers. A CCG interviewee described how the contracting team was effectively working as part of one virtual team with the trust contracting staff. The CCG staff were becoming a system resource.

Now in some senses we're almost moving to a place where you have your own organisational team, but then part of that team moves into a system team that sits in the middle of us all. And that's how I see some of my teams now, [they] are system teams and system resource. That you almost drop back in your organisational box and do what you need to do to get your organisation across the line, but then most of your time is spent on your systems base. Some people find that harder than others because it's not as black and white.

(CCG interviewee)

For finance professionals, we heard that this new way of working can be a challenge – shifting from a more 'black and white' numbers-based role to one based on relationships and having different kinds of conversations with clinicians and finance staff within their main provider organisations. We also heard that CCG staff working on quality found their roles shifting away from monitoring and more towards quality improvement work.

A key part of the new approach is that the NHS organisations across Bradford district and Craven are starting to take a system view of recruitment and role development, rather than just considering the needs of their individual organisations. For example, when the CCG finance director retired, the finance director from the local trust stepped into a system-wide finance role, with the support of funding from the CCG. 'System leadership' roles have also been codified into the job description of senior staff – such as the two new chief executives of the acute trusts.



What are the benefits of this approach?

So far, the main benefits of the approach have been in improving relationships and through provoking different kinds of conversations locally. For example, the two acute trusts in the area now have a collaboration programme that enables them to support each other rather than compete for patients.

Collaboration has bred further collaboration, and one interviewee gave the example of efforts to redesign their diabetes service as an illustration of this. Rather than put the diabetes service out to tender, the CCG committed to staying with the same providers and brought them together to develop a new pathway where any savings generated could be reinvested into the model. Although it is proving difficult to agree a model that is affordable for the system (where the population is at particularly high risk of diabetes), the programme has brought significant organisational development benefits. It prompted the local GPs to form a GP partnership and set up as a community interest company (the Bradford Care Alliance), and led to the establishment of an alliance of local VCS organisations and a provider alliance between all providers across sectors. Interviewees told us that once you start to work in a collaborative way, it can become infectious.

How did they make it happen and what are the ongoing challenges?

The new approach in Bradford district and Craven is powered by effective leaders who empower staff to work differently. Collaboration started from the top, and these relationships then model how others in the system should be working.

I've got a really good relationships with the chief execs and they're probably my most important relationships because if you can't get that one-on-one and you have that relationship, you can't then ask your teams to work in that way.

(CCG interviewee)

There is a focus on empowering staff to work in new ways. A number of interviewees from the CCG told us this was particularly noticeable when they worked with staff from other areas who did not have the same level of trust and autonomy to innovate and work differently.

The system also has a history of collaboration that predates the 2017 partnership agreement – so the ways of working came first, and formal agreements have followed.



The relatively good performance of the CCGs means they have a good reputation and can get on with implementing their approach without much interference from NHS England and NHS Improvement. The CCGs can challenge national NHS bodies and feel empowered to work differently, in part because of the experience of senior staff and their experiences working across the system in a range of different roles, including at NHS England.

There are, however, a number of ongoing challenges in the development of the approach. Interviewees told us that they have to constantly return to their principles and reassert them to ensure that they do not revert to 'old' behaviours, particularly given the financial challenges facing the area.

Different commissioners within the ICS are also taking different approaches to developing their roles: some are focused more on procurement, which can make joint working across the patch challenging. It is also challenging for providers to be working with a range of CCGs who each have different procurement approaches, as they have to adapt their ways of working to each.

National guidance has sometimes put barriers in the way of local system developments – for example, adapting the primary care networks guidance to their CCG context (where community level partnerships were already established) was challenging and slowed down neighbourhood-level integration efforts.

Where are they heading next?

The three CCGs will be merging in April 2020, so a major immediate focus is successfully bringing the separate organisations together. They have developed a strong vision for the changing role of the commissioner in their system and their partnership working approach. However, they are still at an early stage of their journey to translate this high-level vision into on-the-ground changes to the way they plan and secure services. And their focus to date has been on improving collaborative working within the NHS; there is still work to be done to develop joint working across the NHS and local authority.

The next steps are to further embed their vision into the way they work – for example, by agreeing the next iteration of their fixed-income contract arrangements and further developing their system-wide finance and quality monitoring arrangements. They also



highlighted the need to develop more collaborative approaches between the different areas of the ICS, and to work more closely with the local authority, particularly in the development of community partnerships. All of this will further their aim of shifting more care into the community and focusing on population health.

Key learning from the Bradford District and Craven approach

- CCGs can play an important role in system conversations by providing challenge and ensuring a population (rather than patient) focus. This is the key contribution that the commissioner brings to system-wide conversations in Bradford district and Craven.
- Local systems should identify areas that are particularly amendable to joint working and develop a collaborative approach there first. In Bradford, they found that collaboration bred further collaboration and helped unlock previous challenges.
- A new collaborative commissioning approach requires changes in some staff roles – particularly in CCG finance and performance teams. Staff need to be supported and empowered to work in new ways and develop the skills needed to have a different type of conversation with providers.



4 Themes from the case studies

In this section we look across the three case studies to draw out key themes, similarities and differences in their commissioning approaches. What emerges is a philosophy of commissioning with some common elements that is being implemented in different ways in each case study site.

A new commissioning ethos

The CCGs in the case studies are developing a new role in their local health economies, based on a relationship-based approach to planning services at place level. They describe their new role as ‘the glue’, ‘a facilitator’, ‘an enabler’ and ‘a connector’, providing ‘a population-eye view’ of issues, and using collaboration and collective leadership to make more effective choices about how to improve population health. This is a significant change from the past, when one CCG interviewee told us their role was (at its most simplistic) to enforce contracts and provoke competition rather than to enable system-wide discussions and promote collaboration.

The change in ethos within these commissioning organisations is part of a broader change in the way systems work together, and has required providers as well as commissioners from the NHS and local authorities to start to collaborate in new ways. In each of our case studies, staff in commissioner and provider organisations talked about a shift in mindset, from prioritising organisational interests to prioritising system interests, and therefore the wider health and wellbeing of the population they serve.

Table 1 summarises some of the key changes reported by interviewees about the role of CCGs and their ways of working with local system partners.



Table 1 A changing approach to commissioning in three case study sites

From . . .	To . . .
Health care focus	Population health focus
Organisational focus	System focus
Contract enforcer	System enabler
Transactions	Relationships and behaviours
Decision-maker	Convener for collective decisions
High bureaucracy, low trust	Low bureaucracy, high trust
Monitoring organisational performance	Monitoring system-wide performance and providing improvement support
Following national guidance	Developing local solutions

Changes to the mechanics of commissioning throughout the cycle

In each of the case study sites, this new commissioning ethos is changing the way commissioners and providers work together to plan and develop services, affecting their work throughout the commissioning cycle. While in all cases the CCGs have a core set of functions that remain unaffected, the emphasis and focus of their work is shifting away from procurement towards collaborative planning and monitoring.

The changes we heard about included the following.

- **Planning and prioritisation** are changing, such that decisions that were previously being taken by the CCG alone are now being taken collaboratively as a system. Examples include Bradford district and Craven's approach to 'decision-making and taking' (see box, p 51), and South Tyneside's approach to allocating its £2 million non-recurrent funding boost (see box, p 30).
- **Budgets** are being pooled across health and social care, most extensively and formally in Tameside and Glossop, where they have created a single integrated commissioning fund spanning the CCG and local authority (see box, p 41).
- **Contractual arrangements** have been simplified to eliminate incentives which do not make sense from a system perspective – for example, the main providers are no longer reimbursed based on activity in any of the sites.



- **Procurement processes** are only used as an approach of ‘last resort’ and have been simplified as much as possible. Services are, in many cases, developed collaboratively in a transparent ‘open book’ way (see p 32 for an example of a collaborative service development approach).
- **Finance and performance monitoring** are changing, with system-wide processes for monitoring spending, activity, performance and quality starting to emerge in all the case study areas. For example, Tameside and Glossop now publishes a single financial report for the system (see p 41), while Bradford district and Craven set up a single finance and performance committee in April 2019.

Risks and the enduring role of commissioning

The assurance and performance monitoring element of these models was the least developed. Although, as already noted, system-wide structures were starting to emerge in all sites, they were being double-run with organisational level processes, because – for example – providers still had to feed organisation-level activity and financial information to NHS England and NHS Improvement. At the roundtable discussion (see Appendix D), some participants raised the concern that more collaborative commissioning approaches could become ‘closed shops’ where conflicts of interest are not identified and managed and decision-making becomes opaque. While our case study sites recognised the potential for these risks, none of the sites had completely moved over to a collaborative assurance approach. Managing these risks will require continued focus if and when these systems further embed collaborative planning.

Some commentators have raised the question of whether commissioning organisations are necessary in this type of collaborative model (Fewtrell 2013). In our case study sites, the commissioner played an important challenging role – addressing the risks outlined above and keeping organisations focused on populations and the system. This role will continue to provide important local challenge at place level even as new assurance processes emerge within ICSs. The involvement of other stakeholders in place-level conversations (including local authorities, the independent sector and the VCS) is also critical to maintaining challenge in these local systems.



Changes that echo developments in wider public sector commissioning

In Section 2 we outlined key elements of the new ‘collaborative’ or ‘community’ commissioning approaches that are developing across public services. Some of the key elements of these new approaches also feature in the changes we saw in our case study sites. They include:

- an emphasis on collaboration as the route to improvement
- arrangements aimed at tapping into the intrinsic motivation of staff
- empowering frontline staff to use initiative and judgement rather than follow rules
- close ongoing dialogue between commissioners and providers throughout the ‘commissioning cycle’
- long-term stable financial arrangements that support ongoing dialogue and collaboration between commissioners and providers.

In this way, the new commissioning approach we saw emerging in our case study CCGs is not unique to health and care. Looking to the future, system efforts to improve population health will be made easier by the congruence in commissioning developments across the public sector.

Another key element of asset-based approaches is efforts to develop a different kind of relationship with local people, in which public services are an enabler of changes that are led by individuals and communities. This is the kind of approach that The King’s Fund has written about in Wigan ([Naylor and Wellings 2019](#)), and needs to be part of future developments in local commissioning.

Collaborative working at place level

We set out to find CCGs that were thinking differently about their role and taking a more collaborative approach. We ended up working with three CCGs that are operating at (or close to) what NHS England and NHS Improvement describes as ‘place level’ (see Section 2, p 15). NHS England and NHS Improvement defines this as a geography of between 250,000 and 500,000 people – often the boundaries of a local authority area. Although the size of our case study sites varied (see Appendix B for a summary of case study characteristics), they were all



co-terminous or approximately co-terminous with one or two local authorities. In South Tyneside, and Tameside and Glossop in particular, this facilitated collaborative work across health, social care, and the wider determinants of health.

More generally, the case studies are relatively 'local' compared with the larger ICSs within which they sit. They show the potential for effective local collaboration between commissioners and providers in an area when there is a clear local identity or relatively closed system in terms of patient flows. Our case studies highlight the importance of preserving, encouraging and supporting this type of local place-based working – and in Section 5 we discuss what might be needed to do this.

No single blueprint

Despite commonality, no single model emerges from our case studies for how commissioning should be organised at this local place level. Each area has developed different organisational structures to support collaboration, is using tools such as contracts and incentives in slightly different ways, and is working over different geographies.

They are all following the energy in their system and focusing on areas where geography, history and context enable the development of a more collaborative and integrated approach. And this means that each area is addressing a different 'collaboration frontier'. For example, in Bradford, they have started with an NHS focus on collaborative work between the three local CCGs and their two main acute trusts. In South Tyneside, they are making the most of their co-terminosity to develop a collaborative approach across health and social care. In Tameside and Glossop, a crisis in the local trust acted as a springboard for greater collaboration between commissioners and providers, and organisational integration across the CCG and local authority. Having the autonomy to collectively agree their priorities and approach together with system partners was a key part of the success in these sites.

In all three areas, neighbourhood-level networks – like the emerging primary care networks – were key delivery mechanisms for place-based planning decisions. However, similar to what was happening at place level, national guidance sometimes stymied collaboration that was already under way by imposing a blueprint that went



against already established relationships and collaborative approaches. In two of the three sites we visited, this was challenging and a distraction.

A different relationship with the ICS

All our case studies sat within ICSs. Yet the larger system arrangements – while important to the CCGs’ strategies – were rarely mentioned by interviewees. They were more focused on the work of fostering place-based collaboration from the bottom up, and had a clear view for what this did and did not include. Those who attended our roundtable contrasted this with their own experiences – where the division of functions between the ICS and CCG was a major preoccupation. This suggests that there is variation across the country in the extent to which the work of the ICS is penetrating into local systems, even in areas where ‘collaboration’ at place level is relatively mature. From our research, we cannot tell whether the lack of penetration in our case study sites was intentional (because the sites did not need the intervention) or not (for example, because communication and engagement with the ICS was not working effectively).

It also raises a key issue about what the role of the ICS should be in supporting the type of collaborative local place-based working that we saw in our case study sites. The focus of policy at the moment is on specifying the role of STPs and ICSs, but our research indicates that this is out of kilter with where much of the innovative and effective collaboration in health and care is happening – at a more local level. In the next section we outline some of the ways that national and regional bodies should include support for place-based innovation in their work.

A mix of formal and informal structures

The case studies were also different in the extent to which they had codified their collaboration into formal structures and financial approaches. Tameside and Glossop has the most structured and formalised model of collaboration. Their organisational structure and financial arrangements are as close to a fully merged commissioner across the local authority and CCG as is possible under current legislation. In Bradford district and Craven, and South Tyneside, the models are based on less formal collaboration (which, conversely, also means they have more structured involvement from local providers), although both areas are looking to formalise the structures in the future.



However, formalised structures should not be seen as the ‘end point’ for these models (although they can be an enabler of this way of working). One of the most compelling approaches to collaborative working that we heard about during our fieldwork was the alliance leadership team in South Tyneside. Despite being an unstructured and informal approach to developing relationships across the system, and being described by one initially sceptical interviewee as ‘the beanbag brigade’, this is the crucible for collaborative working and was central to the culture change being enacted in their system. The case studies show that the benefits of collaboration can be reaped within current organisational structures without major reorganisations – something that is also reflected in international experiences of collaborative working, as in the Canterbury system in New Zealand ([Charles 2017](#)).

Staff working differently and culture change

While policy tends to focus on changing the roles, functions and organisational structures of commissioning (see Section 2), it quickly became clear to us that the biggest changes in our case study sites were fundamentally about staff working differently and changing the organisational culture. This finding is common to other population health-focused local change initiatives, such as the work being undertaken in Wigan by the CCG and council ([Naylor and Wellings 2019](#)).

After years of working within a market-based system focused on procurement, the new commissioning ethos has meant commissioners asking some of their staff to work in new ways, and has required some changes to the skills and behaviours they need to do their jobs effectively.

In all three case study sites we heard about changes in staff roles – most notably in the CCG finance and performance teams, where some staff were starting to work differently with providers. This included: taking a more relational approach; working with staff from many different departments within provider organisations (not just those based in the finance and performance teams); doing more quality improvement rather than quality monitoring work; working on prospective service developments rather than retrospective monitoring activities; and, in one case, a staff member being embedded in a provider to help develop activity and finance reports for the whole system. We heard that all of this can be hard work and takes commitment from leaders and staff to achieve.



Staff recruitment was also starting to be affected by the shift in mindsets from prioritising organisations to prioritising systems. Our case study sites were starting to think about the skills and roles needed by the system when filling vacancies, and this sometimes meant redesigning roles, passing roles on to staff in other parts of the system, or holding back on recruitment until system needs became clear. In the next section, we highlight the importance of STPs/ICSs and national NHS bodies supporting commissioners as they undertake what, for many, will be a major programme of change for staff.

A common set of enabling factors and challenges

In our case study sites, the challenges that interviewees told us they faced when enacting change, and the enablers that helped them along the way, were similar to those experienced by other areas taking a collaborative approach to place-based working (Naylor and Wellings 2019). They mirror at place level what ICS and STP leaders describe experiencing across larger geographies (Timmins 2019). They are also similar to what health and social care staff experience when working together to deliver more co-ordinated care in local delivery teams (Robertson *et al* 2014). The box summarises the most commonly cited barriers and enablers of change.

A major theme is that collaboration takes time and requires investment in the development of strong relationships over years, if not decades. Maintaining new ways of working requires the constant reassertion of an agreed vision; all three

Barriers and enablers to implementing a new approach to commissioning

Enablers of change

Effective collective leadership and long-established relationships

- A history of collaboration and well-established relationships between system leaders.
- Leaders who role-model the behaviours they want to see in the system in the way they collaborate as a senior team.
- In some cases, change was only able to happen when leaders who were not on board with the new way of working left the system.



Clear vision

- An agreed vision for ways of working to which senior leaders from across the system are fully committed. The vision provides an important backstop when organisations inevitably revert to siloed behaviours in pressured situations.
- Willingness to take risks to achieve that vision, including pushing forward with an approach despite challenges such as potential conflicts of interest.

Local geography

- The relatively 'closed' nature of these systems, where providers draw most of their patients from the main CCG(s), meant there was a clear set of providers and commissioners who could effectively collaborate to bring about change.
- Co-terminosity with the local authority enabled collaboration across health and social care.
- A strong sense of local identity and attachment to 'place'.

Finance and performance issues

- Financial and performance difficulties in some cases created the initial impetus to start to work differently as a system.
- More recently, strong performance and a good reputation freed these commissioners from interference by national NHS bodies and empowered them to challenge national requirements and guidelines.

Investment to support change

- External support – including coaching for leaders, facilitation support for collaborative decision-making structures and transition funding to support the development of new initiatives.
- Investment of staff time and resources in the development of relationships and organisational development.

Barriers

- Tight **finances**, which dragged organisations back to focusing on their bottom line rather than system needs.
- Linked to this, **national NHS bodies** continuing to regulate organisations rather than systems, which sometimes led to siloed behaviours during system-wide discussions.



- Providers are often working with a range of CCGs who are working in different ways and using **different contract and payment approaches** – this is complicated for them in terms of organising their services and administering their contracts.
- Bringing **independent, voluntary and community sector providers** into the collaborative decision-making approaches, when there are multiple small providers in an area.
- **Ingrained behaviours** that have developed over years – for example, more combative approaches to contract negotiation and performance management, and focusing on organisational interests above system needs.

case study sites found it challenging to maintain collaborative approaches when under strain and in an environment where regulators were more often holding organisations rather than systems to account for performance. The local nature of some of the enablers of change shows how critical it is that local areas are given flexibility to develop a change approach that works for their local system, rather than following a national blueprint. This is something we return to in the next section.

Improved decision-making and more co-ordinated services

Although it is difficult and too soon to prove a link between the new commissioning approaches and outcome measures such as improvements in population health, interviewees spoke positively about the impact of their new approaches, highlighting a range of benefits. Most directly, all the sites said they were having a different type of conversation as a system, and this was improving their decision-making. The more collaborative and transparent approach meant that issues were more easily identified, understood and addressed by organisations across their patch.

Specific service improvements cannot be wholly attributed to a change in commissioning ethos, but interviewees gave examples of improvements in services that came from ideas generated through their new collaborative decision-making structures or from cultures and approaches that were supported because of the new approach. These were mainly service improvements that involved integration across organisational boundaries. One example is the new trusted assessor model for Continuing Healthcare in South Tyneside, which replaced a set of bureaucratic and difficult-to-navigate approval processes involving multiple commissioners (see p 32).



5 Implications for local systems and national policy and practice

In this section we draw out the implications of our case study findings: first by considering what other commissioners and local systems can learn from the experience of Bradford district and Craven, South Tyneside, and Tameside and Glossop; then by highlighting their implications for national and regional bodies.

What can other areas learn from these case studies?

The three CCG case studies in this report are not representative of commissioners across England. They exist in fairly closed systems and they are also relatively small 'places' compared with their much larger ICS areas (in contrast to some parts of the country where the ICS is covered by a single CCG – see Section 2). Their relatively good performance means that they are areas that have been able to go under the national radar to some extent. They have the confidence to (and have been allowed to) work around national guidance and take their own path. The case studies are also at different stages of development and each continues to face challenges in different parts of their commissioning functions.

This means that they do not provide a model that other CCGs can 'drag and drop' into their local system. However, their efforts to redefine the role of commissioning at the level of local 'place' and to work differently with local partners do provide some clear lessons for others who are trying to evolve their approach. These lessons include the following.

- **Local systems need to invest in developing relationships and changing ingrained behaviours.** Whatever geography a CCG is working over, effective commissioning requires strong relationships between commissioners from the NHS and local authority and providers from all sectors. These relationships will not develop well without investment in organisational development and



the commitment of staff time to relationship-building. Moving away from the market requires a change in the culture within commissioners and providers that has been built up over the past 30 years – a challenge that should not be underestimated.

- **Agreeing a set of behaviours that will underpin partnership working is a useful first step.** In all our case study sites, a clear set of partnership principles and behaviours provided a crucial fall-back when difficult decisions had to be made and organisations were (inevitably) tempted to revert to protecting their organisational interests. Pooling sovereignty and being comfortable with giving up power – along with a commitment to transparency and consensus decision-making processes – were key underpinning behaviours in all sites. Back-up arrangements were also important where consensus could not be reached – for example, a voting system in Tameside and Glossop that only had to be used on one occasion.
- **Change will not happen without effective leadership, role-modelling and senior-level commitment across the system.** Experienced, motivating leaders were driving change in all three sites. We also heard that symbolic gestures of collaboration can provide a strong signal to staff within the system that leaders' commitment is real. Leaders had to continually actively lead and manage behaviour change in line with their new conception of roles in the system. They were also sometimes required to confidently push forward with local solutions rather than looking to national NHS bodies for guidance.
- **Collaboration depends on relationships, and systems should focus first on the areas most amenable to change.** Each of our case study sites took a different approach to collaboration depending on factors like their geography, the success of past collaboration efforts, relationships between local leaders, and financial and performance factors in the system. In some instances, change only became possible when all leaders were on board with their more collaborative vision. We heard that collaboration can breed collaboration, so success in addressing one 'collaboration frontier' and particularly amenable issues across that frontier may breed further success in future in areas that are less amenable to change.
- **Procurement approaches and local incentives can be adjusted to support rather than inhibit collaboration.** As is happening in many parts of the country, our case study sites were developing new contracting and procurement



approaches to support a more relational way of working. However, these were a fall-back; the main way change happened in these systems was through partners having a different type of conversation, rather than through detailed contract development and enforcement activity. Local systems need to work with independent, voluntary and community sector providers to ensure that changes to incentive structures and procurement approaches do not constrain patient choice.

- **Expect double running in decision-making and assurance processes.** In all our case study sites, the legal framework for CCGs and the approach of national NHS bodies to assurance meant there was significant double running, with a new system-wide process established, but organisational processes continuing to satisfy national requirements.
- **A system-wide approach to recruitment can help embed new ways of working.** Our case studies show that staff roles are changing as the commissioning philosophy evolves. Some commissioning staff are also becoming more of a 'system' rather than 'organisation' resource and the skills needed by finance staff in particular are changing. Thinking about system needs when recruiting new staff is a key part of embedding and spreading the approach.
- **Planning skills and the ability to look at population rather than organisational needs remain important.** As system-wide approaches develop, it is important that local systems do not forget the importance of commissioning skills in local planning. Commissioners can bring a unique population focus and skills in planning, clinical service procurement, cross-sector pathway design and monitoring that remain essential. Regardless of what happens to CCG structures, these skills remain important at 'place' level (and therefore cannot be completely replaced by ICS/STP-level functions).
- **Maintain clinical involvement and extend it to other professionals working for population health.** Evidence from past commissioning initiatives shows that clinical involvement supports innovation (see Section 2). New collaborative decision-making structures need to retain the benefits of clinical involvement but also consider what other professional involvement is needed as the focus shifts to population health. For example, not only are the views of a wide range of clinicians important, there are also professionals working on the wider determinants of health – such as social workers, welfare staff and educators – who have knowledge that is crucial to local decision-making. Participants at



our roundtable felt it was particularly important to extend clinical involvement to reflect this broader group of professionals with an interest in population health.

- **The voluntary and community sector, the independent sector, and patients and the public are key partners in collaborative approaches to commissioning.** In our case study sites, engaging these partners was an ongoing challenge, particularly in the absence of overarching representative bodies. However, a population health approach will not work without genuine involvement from these partners, so this needs to be a strong focus for the future. There are lots of opportunities for commissioners to share learning – for example, CCGs can learn from local authority approaches to working with both service users and non-statutory provider organisations, and should make the most of their system resources to involve and engage with them.
- **Local collaboration between commissioners and providers at place level brings significant benefits, and ICSs/STPs have a key role to play in preserving and supporting its development.** Our case studies clearly show the value of commissioners working with providers and local authority partners at the level of place. Whatever end state emerges for the structure and role of ICSs, our findings indicate that it must not undermine the value of place-based working in smaller geographies and the role and structure of CCGs needed to facilitate that. This is the vital if local areas are to achieve their full potential in improving population health. Preserving and supporting place-based working needs to be an important part of the ICS role.

What are the implications for national policy and practice?

Since 2013, national policy has resisted developing a single blueprint for the structure of the NHS's commissioning function. Instead, NHS England and NHS Improvement has set out a suggested path, giving local areas flexibility in how they chose to follow it (see Section 2).

As national policy continues to evolve and NHS England and NHS Improvement regional teams and ICSs/STPs establish themselves and develop their structures and roles, our research highlights a number of issues they should consider that relate to the collaborative place-based approach to local planning we saw developing in our case study sites.



- **Our case studies show the benefits of place-based collaboration between commissioners and providers in local geographies.** This joint working across the NHS and local authorities makes the most of local assets, creates different types of conversations, helps remove perverse incentives and blockages in local systems, and supports the implementation of population health-focused planning strategies in some parts of the country.
- **There is a risk that CCG mergers undermine the benefits of place-based working; NHS England and NHS Improvement should therefore be permissive rather than prescriptive about the future shape of commissioning organisations.** This means holding their nerve on the non-restrictive policy that has characterised their approach to date. It means that rather than stipulating the structure and size of CCGs within ICSs, they should listen to local leaders and their insights about what works in each area and take decisions on a case-by-case basis.
- **The new NHS England and NHS Improvement regional teams have a key role to play in supporting (and not inhibiting) the development of these models, so must develop a consistent approach that does not thwart place-based working.** At our roundtable we heard that there is currently variation in the approach taken by regional teams. This includes variation in the extent to which local commissioners can define their preferred end-state structure and permissiveness around moving away from a procurement focus. As local areas develop approaches based on relationships, which may vary considerably in different parts of the country, consistency in regional oversight is increasingly important to ensure that innovation is not stifled while also ensuring that risks are managed effectively. The organisational development task within the NHS regions associated with this should not be underestimated and will require investment.
- **National assurance processes need to evolve to better reflect the way commissioning and provision is changing. This includes striking a better balance between local autonomy and national line of sight, and continuing to adjust the focus of national assurance towards systems rather than organisations, to fit with the shift from acute care to population health.** Our case studies show the benefits of collaborative, relationship-based approaches to local planning and oversight – but these systems are fragile and dependent on individuals and their intrinsic motivation to do the right



thing. NHS England and NHS Improvement will need to work with ICSs to give them some genuine autonomy in their oversight function, while setting clear expectations that whatever arrangements develop locally need to address the risks inherent in this type of system. These include: ensuring that local systems manage conflicts of interest effectively – retaining challenge through both the commissioner and ICS functions; minimising the need for double running of processes; involving clinicians, other health care professionals, and patients and the public in decision-making; retaining a focus on value for money; and continuing to collect the data necessary for oversight and improvement, even when payment mechanisms are changed.

- **National bodies should support leadership and organisational development in CCGs.** The changes to commissioning require a major culture change based on the reversal of years of market-based incentives in the system. The 19,000 FTE staff who work in CCGs ([NHS Digital 2019](#)) have been through numerous structural changes over the past 15 years and more are coming. The organisational development challenge for commissioners is not small, and national NHS bodies and ICSs have a role to play in supporting staff through the changes. This includes developing the skills necessary to support change within commissioning organisations, and new skills needed in a more collaboration-focused system. It might also include facilitating networks to help leaders share and learn from the experiences of others, and setting expectations for CCGs and local systems about organisational development within their organisations. National organisations also have an important role to play in valuing, supporting and trying to retain CCG leaders who are driving these initiatives; these are complex change projects, and those driving change are often not recognised for their innovative work.



Appendix A: Methodology

This report is based primarily on data gathered during visits to three case study sites:

- South Tyneside
- Tameside and Glossop
- Bradford district and Craven.

These sites were identified through informal conversations with a range of stakeholders working locally and nationally in the NHS and through insights from staff at The King's Fund who are working with local systems. They were selected on the basis that they were thinking differently about commissioning – ie, they had developed a vision for a new commissioning role in their system, and they had started to use this to change the way they undertook their day-to-day commissioning functions. They are not intended to be representative of commissioners across England.

In total, we interviewed 39 people across the three case study sites. We spoke to a range of stakeholders in each site, including:

- CCGs
- local authorities
- NHS providers
- a commissioning support unit.

Interviewees were asked to describe the approach taken to commissioning in their area and their experience of it, as well as how this was changing decision-making, procurement and monitoring approaches in the CCG. They were also asked about the impact of the new way of working and their plans for the future.



Most interviews were conducted face-to-face, with some conducted by telephone to accommodate interviewees' diaries. Interviews were recorded and transcribed; the authors analysed the transcripts thematically. Quotations are used in a non-attributable way, with a broad organisational category used to indicate where the interviewee was employed.

Ahead of each case study site visit, we reviewed relevant publicly available documentation such as CCG and trust board and strategy papers, to understand their commissioning approach. The case studies and the interview data both draw on these.

After completing fieldwork in our case study sites, we convened a roundtable discussion with a group of expert stakeholders to outline our emerging findings and explore participants' views on their implications for local systems and national policy. Participants were drawn from NHS providers, CCGs, local authorities, STPs/ ICSs, those working in system roles, representative groups, and policy-makers and academics. The discussion was held under the Chatham House rule.

The framing of the report was also shaped by a wider literature review exploring the history of commissioning in the English NHS and wider public services.



Appendix B: Background information on case study sites

	South Tyneside	Tameside and Glossop	Bradford district and Craven
CCG(s)	South Tyneside CCG	Tameside and Glossop CCG	Airedale, Wharfedale and Craven (AWC) CCG Bradford City CCG Bradford Districts CCG
Estimated registered population (2018/19)	157,204	247,905	AWC – 159,178 Bradford City – 140,423 Bradford Districts – 333,179 Total – 632,780
2019/20 CCG budget allocation (£000s)	£332,828	£487,819	AWC – £283,134 Bradford City – £225,001 Bradford Districts – £592,609 Total – £1,100,744
2018/19 CCG Improvement and Assessment Framework (IAF) rating	Good	Outstanding	AWC – Good Bradford City – Outstanding Bradford Districts – Outstanding
Number of GP practices	22	37	AWC – 16 Bradford Districts – 35 Bradford City – 25 Total – 76



	South Tyneside	Tameside and Glossop	Bradford district and Craven
Key NHS providers (and current CQC ratings)	<p>South Tyneside and Sunderland NHS Foundation Trust (see note 1) (CQC: not currently rated)</p> <p>CQC ratings for constituent organisations pre-merger:</p> <p>City Hospitals Sunderland NHS Foundation Trust (Good based on 2018 inspection)</p> <p>South Tyneside NHS Foundation Trust (Requires improvement based on 2017 inspection)</p> <p>Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (see note 2) (CQC: outstanding)</p>	<p>Tameside and Glossop Integrated Care NHS Foundation Trust (CQC: good)</p> <p>Pennine Care NHS Foundation Trust (CQC: requires improvement)</p>	<p>Bradford Teaching Hospitals NHS Foundation Trust (CQC: requires improvement)</p> <p>Airedale NHS Foundation Trust (CQC: requires improvement)</p> <p>Bradford District Care NHS Foundation Trust (CQC: requires improvement)</p>
Local authorities	South Tyneside Council	<p>Tameside Metropolitan Borough Council</p> <p>Derbyshire County Council</p> <p>High Peak District Council</p>	<p>Bradford Council</p> <p>North Yorkshire County Council</p> <p>Craven District Council</p>
ICS key information	<p>North East and North Cumbria ICS</p> <p>3.2 million population</p> <p>12 CCGs</p>	<p>Greater Manchester Health and Social Care Partnership</p> <p>2.8 million population</p> <p>10 CCGs</p>	<p>West Yorkshire and Harrogate Health and Care Partnership</p> <p>2.6 million population</p> <p>9 CCGs (will be fewer from April 2020)</p>
NHS England and NHS Improvement region	North West	North East and Yorkshire	North East and Yorkshire



	South Tyneside	Tameside and Glossop	Bradford district and Craven
Key population health indicators	<p>Healthy life expectancy (HLE) at birth among men (2015–17): 59.4</p> <p>HLE at birth among women (2015–17): 58.8</p> <p>Life expectancy at birth among men (2015–17): 77.7</p> <p>Life expectancy at birth among women (2015–17): 81.7</p>	<p>HLE at birth among men (2015–17): 58.1</p> <p>HLE at birth among women (2015–17): 57.6</p> <p>Life expectancy at birth among men (2015–17): 77.5</p> <p>Life expectancy at birth among women (2015–17): 80.8</p> <p>(NB: data for Tameside rather than Tameside and Glossop)</p>	<p><i>Bradford</i></p> <p>HLE at birth among men (2015–17): 60.4</p> <p>HLE at birth among women (2015–17): 59.0</p> <p>Life expectancy at birth among men (2015–17): 77.7</p> <p>Life expectancy at birth among women (2015–17): 81.6</p> <p><i>North Yorkshire</i></p> <p>HLE at birth among men (2015–17): 64.9</p> <p>HLE at birth among women (2015–17): 68.1</p> <p>Life expectancy at birth among men (2015–17): 80.6</p> <p>Life expectancy at birth among women (2015–17): 84.2</p>

Sources: Airedale, Wharfedale and Craven CCG 2019; Bradford City CCG 2019; Bradford Districts CCG 2019; NHS England 2019a; NHS England and NHS Improvement 2019a; Public Health England 2019; South Tyneside CCG 2019a; Tameside and Glossop CCG 2019.

Notes:

1. South Tyneside and Sunderland NHS Foundation Trust was formed in April 2019 from the merger of City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust.
2. Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust was formed in 2019 when services previously delivered by Cumbria Partnership NHS Foundation Trust were transferred to Northumberland, Tyne and Wear NHS Foundation Trust.



Appendix C: A summary of key models of NHS commissioning since 1991 and evidence on their impact

Health authorities and GP fundholding, 1991–9

At the launch of the internal market, commissioning responsibilities were divided between several organisations: regional health authorities, which planned specialised services; district health authorities, which commissioned acute, mental health and community services; and family health service authorities, which planned primary care services. Alongside this, fundholding offered GP practices (or groups of practices) the option of taking control of budgets to buy some elements of hospital care and community services for patients and the public. Legal responsibility remained with the district health authorities, which sat above fundholding GPs. Participation increased over time so that by 1997, approximately half of all GP practices in England were fundholding.

Claims about the benefits of fundholding generally focus on two areas: (1) participating practices moderated growth in primary care prescribing costs by increasing the use of generics (at least for a period of time) (Gosden and Torgerson 1997); and (2) they secured shorter waiting times for their patients undergoing (certain types of) elective interventions (Propper *et al* 2002; Dowling 1997). Some other studies pointed to a broader set of benefits around more responsive services – for example, a wider array of services delivered in community settings ([Audit Commission 1996](#)). Concerns focused on the inequality built into a voluntary system and the administrative costs associated with many small-scale commissioning organisations (Mannion 2011).

Locality commissioning, 1994–9

Alongside fundholding, a number of alternative approaches emerged, largely from the bottom up, to enable GPs' expertise and local insights to shape health



authorities' commissioning decisions – mostly without taking on delegated budgets. In locality commissioning, groups of GP practices came together to influence the commissioning decisions of health authorities in a structured way (even though the practical form that this took varied).

Fewer in number than fundholding practices, evidence is limited regarding the impact of locality commissioning. An evaluation of locality commissioning initiatives in Avon found some service change in primary, mental health and community services, and at a lower management cost than other initiatives (partly thanks to GPs' discretionary effort) (Hine and Bachmann 1997). Other locality commissioning initiatives in County Durham and Newcastle demonstrated evidence of some service development, again in primary and community care, and improved relationships in the local systems. Real traction on provider behaviour proved elusive, however, and success partly depended on the relationship between localities and their health authority (Smith and Shapiro 1997).

Total purchasing pilots, 1995–9

Alongside the development of fundholding, total purchasing pilots were introduced to enable groups of GP practices to commission a broader spectrum of services – potentially all hospital and community services. A total of 88 pilots were supported in two waves over 1995 and 1996. The pilots, however, enjoyed a lesser form of budgetary autonomy than fundholders.

Early findings from the pilots showed that they did not purchase all health care services; rather, they focused on shaping certain services (such as developing primary care or community services) (Mays *et al* 2000). There was some evidence that hospital length of stay was reduced in the most effective sites (Goodwin *et al* 1998). Performance varied across the cohort of pilots, with smaller rather than larger pilots more likely to deliver results. The ascendant Labour Party's pledge to abolish versions of GP fundholding hindered the pilot areas' ability to secure wider buy-in from system colleagues (Smith *et al* 2004).

GP commissioning, 1998–9

In place of fundholding, the Labour government introduced GP commissioning in 40 initial pilots. The sites included a range of approaches with different services in scope; budget responsibilities similarly varied, from advisory input to health authority decisions to delegated budgets (all pilots held a real budget for primary



care prescribing). A two-year evaluation was planned, but midway through, the government announced the establishment of primary care groups by April 1999. Key learning from the pilots focused on the time and energy associated with building the infrastructure of commissioning arrangements, and the need to be realistic about how much clinical resource would be consumed by commissioning work (Regan *et al* 1999).

Primary care groups, 1999–2002

Introduced in 1999, primary care groups' remit focused on commissioning primary, community and hospital services. Initially there were 481 primary care groups across England, with resident populations ranging from 50,000 to 250,000. GPs were mandated to be involved in these groups and were allocated to footprints (primary care groups also included wider clinical input). The intention from the beginning was that primary care groups would progress to becoming primary care trusts. A four-level maturity framework was developed to chart their evolution from advisory primary care groups (working with their local health authority) to autonomous, budget-holding primary care trusts. In practice, the government announced the national roll-out of PCTs by April 2002.

Primary care trusts, 2002–13

In total, 303 PCTs were created in 2002. These were hybrid organisations: commissioning the bulk of health services while also providing community services. Around 100 health authorities were replaced by 28 strategic health authorities (SHAs) intended to provide additional direction and performance management of PCTs. In 2006, the number of SHAs was cut to 10 and PCTs were rationalised to 152 (most of which were co-terminous with local authorities).

PCTs were widely perceived to dilute the clinical (particularly GP) input into commissioning decisions (Lewis *et al* 2003). Increasing administrative costs caused concern (Health Select Committee 2010), although representative bodies noted the expanding portfolio of responsibility PCTs were amassing (NHS Confederation 2011). Studies pointed to only a minority of PCTs making real headway in redesigning care pathways that spanned the primary/secondary care interface (Audit Commission 2004a). As with other models of commissioning, it was more common for PCTs to focus on changing the disposition of primary care services (Audit Commission 2004b).



Practice-based commissioning, 2005–13

Launched in April 2005, practice-based commissioning aimed to empower GPs to shape services by affording groups of practices indicative budgets to commission services. The scope was flexible, but there was a focus on hospital care, with a view to rebalancing total spend towards out-of-hospital services. PCTs remained legally responsible for any potential overspends, and the extent of the delegation from PCTs varied across the country. Involvement by GPs was voluntary.

Evaluations of practice-based commissioning found limited impact. Implementation varied across the country, partly dependent on local history (Coleman *et al* 2010). Some small-scale change to services was delivered in the early years, particularly focused on broadening the service offer outside of hospitals, and local systems saw improved relationships (Goodwin *et al* 2008). In some cases, tensions between PCTs and practices undertaking practice-based commissioning, over financial arrangements, led to operational delays (Checkland *et al* 2011).

Clinical commissioning groups (CCGs), 2013 to date

In April 2013, 211 CCGs went live, replacing PCTs as the key local commissioning organisations. It was compulsory for GP practices to be a member of a CCG, with each commissioning group's activities overseen by a governing body that had to be chaired by a clinician (and generally includes several GPs from member practices) and had to include other clinical and lay representation. The remit of CCGs spanned community services, acute physical care, and mental health services, with other commissioning responsibilities handed to local authorities (eg, some public health services) and NHS England (eg, screening programmes and specialised services).

Early research exploring the development of CCGs found them working to improve primary care services (Naylor *et al* 2013), but raised questions about the extent to which clinical leaders' involvement could be maintained in the future and about their capability to deliver an expanding portfolio of responsibilities (Robertson *et al* 2015). More recently, research has explored whether the changes have fed through into any measurable changes in service quality or outcomes – finding no evidence that they had. It also pointed to the divided commissioning responsibilities across service areas as a particular issue for service co-ordination (Checkland *et al* 2018).



Appendix D: Key points from the roundtable discussion

To inform this research we convened a roundtable at The King's Fund on 22 October 2019 to discuss emerging findings with a group of expert stakeholders. Participants included commissioners and providers based in local health and care systems, national NHS bodies, and policy and academic organisations. The discussion was held under the Chatham House rule.

The authors briefly presented headline findings from the research, and participants engaged in structured discussion exploring two key themes:

- implications for local systems
- implications for national policy and bodies.

Key points from the discussion about local systems included the following.

- Participants noted that the case study sites are relatively small – populations of 150,000 to 600,000 – compared with the new CCGs forming via mergers. In the parlance of ICSs, our case studies are developing distinctive commissioning approaches at the level of place. However, different parts of the country (for example, in London) are conceptualising the system tiers differently so the applicability is likely to vary.
- In our case study sites, local ICSs were a relatively distant presence – this surprised our roundtable participants, who said this varies around the country. In some of the areas where they were based, there is a live discussion about which commissioning functions should sit at the different levels of the ICS.
- A key question is how can ICSs best support these types of place-based approaches to flourish?
- A question was raised about the future of clinical involvement in commissioning. A range of issues were discussed. Some participants



highlighted a need to ensure that clinical voice is retained in these emerging commissioning approaches (and broadened to include nurses, allied health professionals and social care professionals). Others raised a question about the future of clinically led commissioning when places are increasingly focused on a wider agenda of place-based public service reforms; professionals other than just clinicians need to be engaged in these discussions. Similar points were made about patient and public involvement.

- The conversation explored the question of the fragility or resilience of these collaborative approaches. Some participants were keen to understand how these collaborative planning approaches can be embedded in formal governance models because relationships are vulnerable to staff turnover. Others suggested that relationships are always crucial in practice.
- Some participants raised questions about ensuring good ‘disciplines’ of commissioning even when embracing a more collaborative way of working. Some perceived a risk that basic processes – fair decision-making process, documentation of decisions and rationales, transparency, and managing conflicts of interest – could be eroded in the name of collaborative working.

Key points from the discussion about national policy and national NHS bodies included the following.

- The discussion explored how national NHS bodies will be able to have assurance that local systems are doing the ‘right’ things. People recognised a risk that embracing high-trust, low-bureaucracy ways of working within local systems could facilitate decisions that are not necessarily in patients’ interests. Hence there is a role for national NHS bodies in developing an oversight model, which gives actionable insight into system performance. What form that system could take was an open question.
- Participants thought that these developing approaches would entail change for national NHS bodies (and highlighted the NHS England and NHS Improvement regional teams as crucial mediators). Views varied on what this would mean in practice: some highlighted the need for national NHS bodies to embark on a fairly fundamental organisational development change process to explore the implications of these ways of working for the national bodies and their staff (eg, inspection practices and accountability enforcement). Others pointed



to more practical asks such as streamlining data collection processes from different arms of NHS England and NHS Improvement.

- Participants raised a question about the extent to which national policy will be able to accommodate the apparent variation in approaches emerging in different local systems (eg, vis-à-vis how CCGs are collaborating with local authorities). There was a consensus that a national push for one-size-fits-all would not be advisable, but people also recognised a risk of untrammelled divergence.
- A question was raised about what tools national NHS bodies will have available to support dysfunctional local systems. Some people were of the view that the existing, more hard-edged regime (data, pricing, contracts, penalties and strict organisational accountabilities) allows national NHS bodies to scrutinise and exert some traction on poorly performing systems. Consequently, they saw embracing a more light-touch, enabling model of oversight as risking exacerbating performance variations.



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Before returning to The King's Fund in 2013, Ruth spent three years at the Commonwealth Fund in New York researching the implementation of the Affordable Care Act and its impact on the uninsured. She previously worked at The King's Fund between 2006 and 2010, when she completed national evaluations of two of Labour's major health system reforms: patient choice and practice-based commissioning. Earlier in her career, Ruth worked as an analyst at the Commission for Health Improvement (a predecessor to the Care Quality Commission) and as a medical secretary at various NHS trusts.

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NHS commissioning was created almost 30 years ago. Planning and provision of services was split into separate organisations to create an internal market so that competition and market incentives could be used to promote efficiency and improve quality. However, over the past five years, there has been shift from competition to collaboration to improve the health system, but how does this affect commissioning processes?

This report seeks to understand how collaborative commissioning approaches are evolving by exploring the experiences of three case study sites: South Tyneside; Tameside and Glossop; and Bradford district and Craven. The authors draw out learning for other areas and explore the national policy implications of this new way of working and what national NHS bodies can do to support its development.

Key findings include:

- the collaborative models emerging in the case study sites have developed to serve footprints that are approximately co-terminous with local authorities. Strong place-based planning functions should be retained in the future
- new ways of working together can be enhanced by developing a sense of shared values across commissioner and provider organisations from the outset
- implementing more relational planning approaches requires different behaviours from staff and involves navigating uncertainty. For some staff this can be challenging, so there is a need to invest in organisational development.

If these approaches are to reach their full potential national NHS bodies have a key supporting role to play. This will have implications for integrated care systems as they expand to cover the whole of England, how NHS England and NHS Improvement's regional teams operate, and wider ways of working among NHS national bodies.

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