The King's Fund Ideas that change health and care

Thinking differently about commissioning

Learning from new approaches to local planning

Overview

- In recent years, national policy within the English NHS has promoted collaboration as a key tool for improving health services. This has profound implications for commissioning.
- We visited clinical commissioning groups in three parts of England where leaders are rethinking the role of commissioning and implementing more collaborative ways of planning services. Their approaches illustrate the opportunities associated with developing collaborative models of planning.
- Their experience suggests that collaborative planning arrangements at place level – on footprints that are often approximately co-terminous with local authorities – will be important in the future and should be supported.
- The report explores the implications of these ways of working for the development of integrated care systems, how NHS England and NHS Improvement's regional teams operate, and wider ways of working among NHS national bodies.

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Why did we do this work?

In recent years national policy has been emphasising the importance of collaboration within local health and care systems. Since the *NHS five year forward view* in 2014, several initiatives, including the new care models programme and integrated care systems (ICSs), have promoted collaborative approaches in which providers from different parts of the NHS or providers and commissioners work together to plan and develop services. The *NHS long term plan* has indicated that ICSs will cover England by 2021.

These developments have major implications for how commissioning operates in practice. Yet recent national policy documents – the *NHS five year forward view* and the *NHS long term plan* – have not provided a national blueprint for commissioning structures. Local systems have instead had scope to evolve commissioning arrangements to suit their circumstances. Consequently, a range of approaches is developing, and different parts of England are at different stages in these developments.

We wanted to understand how commissioning arrangements are developing in practice. Our goals were to:

- understand the approach being taken by some clinical commissioning groups (CCGs) and local systems that are re-thinking 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 bodies can do to support its development.

Our research approach

We identified two CCGs and one group of CCGs that were implementing new ways of planning services. These were:

- South Tyneside – a CCG in north-east England that is adopting a service planning model based on the approach of the Canterbury health system in New Zealand
- Tameside and Glossop – a CCG in Greater Manchester which has come together with Tameside Council to create a single planning organisation for most local public services
- Bradford district and Craven – three CCGs in West Yorkshire that will be merging in April 2020 and are establishing partnership arrangements to plan services.

We interviewed a range of stakeholders – around 40 in total – working in each local system. Subsequently, we convened a roundtable with commissioners, providers and representatives from sustainability and transformation partnerships and ICSs in other parts of England as well as national organisations and academics to test our findings and explore the implications for national policy and practice.

Our findings

Common across our case study sites was a new ethos of commissioning. Traditional notions of commissioning are no longer guiding their way of working. Instead, these areas are focusing on new ideas around how commissioners can add value to local systems: bringing stakeholders together to make decisions; fostering close operational partnership between commissioners and providers; simplifying financial arrangements; and offering improvement support to providers.

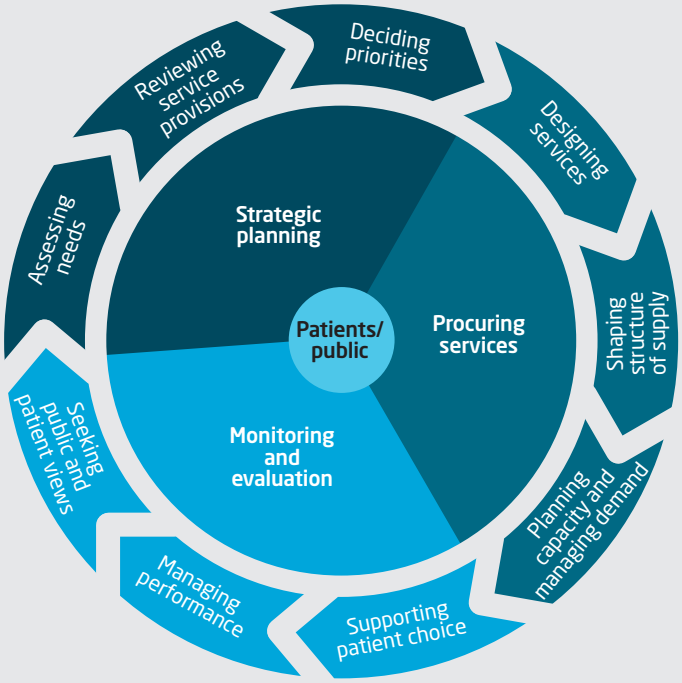
Each case study site has used different combinations of these ideas and uses slightly different language to describe its role, for example, being a 'facilitator', 'enabler' or 'connector'. But collectively their ideas add up to a paradigm shift in thinking about their role and how to drive improvement in health and care services. The table, below, summarises some of the key changes we saw.

Table 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

These different ways of thinking are driving tangible changes in how these commissioners deliver their functions throughout the commissioning cycle – strategic planning, procurement, and monitoring and evaluation (see Figure).

Figure The NHS commissioning cycle



Source: NHS England undated

- Strategic planning is increasingly a collective activity in which system partners come together to understand available resources, explore local population needs, agree priorities and make resource allocation decisions looking across health services (and in some cases, across health, social care and wider public services).
- Procurement processes are being simplified wherever possible. Areas are using competitive procurement as a tool of last resort. At the same time, financial arrangements between commissioners and acute providers are being simplified – through block or aligned incentive contracts – to tackle incentives that create tension within the system.
- Performance monitoring increasingly focuses on the performance of the local system rather than individual organisations. For example, some places are implementing system-wide financial reporting and focusing on population health outcomes as the key indicator of system performance. Monitoring and evaluation are the least developed parts of these new models of commissioning.

Case study sites are implementing these changes in different ways. Each place has different priorities based on local history and organisational context. Bradford district and Craven is focusing on collaboration among NHS organisations while

South Tyneside and Tameside and Glossop is focusing on collaboration between the NHS and local government.

Strong relationships among key stakeholders are central to these new ways of working. Building mutual understanding between commissioner and provider leaders in local systems takes time – but is essential. Developing shared views and understanding among senior leaders go alongside a wider process of change for operational staff that focuses on supporting them to work more effectively with colleagues in other local organisations.

All our case study sites are developing or have developed structures to support collaborative service planning. But formal changes to organisational structures and governance arrangements are only one part of their change processes. Informal mechanisms for kickstarting change and role-modelling collaborative values are essential as well. In South Tyneside, for example, an alliance leadership team, which brings senior leaders together to discuss operational challenges, is central to how local organisations work together without being a formal decision-making meeting.

Changes to the commissioning process have led to changes in some staff roles. CCG finance and performance teams are increasingly taking a relational – rather than compliance – approach with providers. Finance and performance functions are focusing on improvement support rather than performance monitoring. In Bradford district and Craven, these developments are being supported by changes to recruitment decisions to meet system needs.

Learning for other commissioners and local systems

Our three case study sites were not representative of the wider health and care system in England: they are relatively self-contained health economies and Tameside and Glossop and South Tyneside are smaller-than-average CCGs. Other parts of England will need to adapt any learning from this study to their local circumstances. Key learning points include the following.

- Agreeing a set of shared values can be a useful resource when challenges arise. Tensions between stakeholders within collaborative planning arrangements are inevitable, but our case study sites found a defined set of values helpful as a way of anchoring conversations at times of difficulty.
- New collaborative commissioning approaches mean commissioning staff may need to work differently. After nearly 30 years of a quasi-market framework, collaborative commissioning requires different behaviours and involves

navigating uncertainty. For some staff this can be challenging; all the case study commissioners were investing in organisational development.

- Clinical involvement in commissioning has changed and will continue to change. As collaborative commissioning arrangements increasingly look to influence population health, a broader range of expertise – for example, from social care and allied health professionals – will be needed in service planning discussions.

Moving to a more collaborative model brings some risks, for example, regarding how to manage conflicts of interest and ensure transparency without introducing unnecessary friction into commissioning processes. While these risks are not unique to collaborative models, they demand careful management. Our case study sites were managing these issues as they arose. However, leaders in the sites felt the costs of managing these risks were far outweighed by the opportunities presented by collaborative planning. Interviewees spoke about how their approaches were enabling different conversations within their local systems which, in turn, were supporting positive change in patient-facing services. Practical day-to-day gains were also clear to staff. All our case study sites intend to continue embedding and refining their ways of working.

Implications for policy and practice

Our case study sites were implementing changes within existing legislative arrangements, but in some ways current regulations obstruct, rather than support, relational ways of working. It takes constant effort to model a collaborative ethos in the face of a legal framework that encourages more adversarial methods.

National policy needs to be adapted and national bodies need to work differently and work with local systems to maximise the opportunities associated with collaborative planning.

- According to current national plans ICSs will be co-terminous with CCGs. Yet merging CCGs by default risks undermining local collaborative planning structures. 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.
- NHS England and NHS Improvement's regional teams have an important role in supporting the development and spread of collaborative commissioning models. As new approaches develop, consistency in regional oversight will be critical to ensure risks are managed effectively and innovation is not stifled.

- National bodies' existing model of assurance is mainly focused on organisations rather than systems, which risks hampering the progress of collaboration. Changes to the assurance regime will need to strike a better balance between organisational and system-level scrutiny as well as national versus local line of sight.
- National bodies should support leadership and organisational development in CCGs. Embracing collaborative models of commissioning entails sustained culture change for staff. National NHS bodies and ICSs have a role to play in supporting this change process.

To read the full report, *Thinking differently about commissioning: learning from new approaches to local planning*, please visit **www.kingsfund.org.uk/publications/thinking–differently–commissioning**