

DRIVING FORWARD SYSTEM WORKING

**A snapshot of early progress
in collaborative commissioning**



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FOREWORD

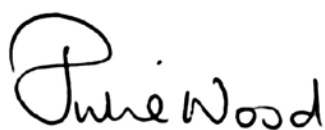
The forthcoming NHS long-term plan is expected to champion collaboration between health and care organisations in local systems as the key mechanism for driving improvement and sustainability. As sustainability and transformation partnerships (STPs) develop and more integrated care systems (ICSs) emerge, the commissioning landscape is evolving to meet the needs of local populations within the new world of system working. In *Steering towards strategic commissioning*, NHS Clinical Commissioners (NHSCC) highlighted the fact that this evolution is happening at pace and set out the future direction for clinical commissioning groups (CCGs) as strategic commissioners (NHS Clinical Commissioners, 2017). It is now timely to revisit the commissioning landscape and explore how providers, too, are adapting their ways of working.

This report, commissioned by both NHSCC and NHS Providers, therefore explores emerging practice in systems that are rethinking the way in which they plan and design services at a local level to support the delivery of joined-up and sustainable care. It revisits views from leaders in CCGs, providers, national bodies and think tanks about the concept of strategic commissioning, particularly as CCGs are increasingly working together to focus on outcomes across larger geographies and reduce management costs. It also explores views about the likelihood that providers will take on more of the activities that NHS England (as a direct commissioner) or CCGs currently undertake – be that to help develop service specifications or lead on pathway redesign.

It is important to be clear that the statutory commissioning functions of CCGs as detailed in the 2012 Health and Social Care Act remain, even if the way in which those functions and associated tasks are transacted is evolving. This may be through clinical commissioners operating at system level, working with providers at place level, or even delegating delivery of those functions to their providers via a range of contractual mechanisms.

This report sets out a shared ambition for clinical commissioners and providers to collaborate as system partners. To help our respective members – CCGs and NHS trusts and foundation trusts – work towards this ambition, we identify a number of barriers and enablers to the development of integrated, collaborative working. While these developments are very much a work in progress, we hope this report provides a useful snapshot of practice at the frontline and working examples for systems to use.

We are grateful to all those from both the commissioning and provider sectors as well as wider NHS stakeholders who participated in this research. We would particularly like to thank Dr Julia Simon for conducting the work that underpins the report and Adrian Parker, partner from the law firm Hempsons, for his input.



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KEY MESSAGES

- Local health and care systems are increasingly working in different and more collaborative ways to make best use of resources and achieve positive outcomes for their local populations. This involves working across organisational boundaries and rethinking the distribution of activities between organisations across a footprint.
- All of the contributors we spoke to were clear that strong, local relationships between clinical commissioners, providers and other system partners form the basis for more collaborative ways of working. A prescriptive approach to integration is unlikely to succeed given the complexity of local relationships and variation in the needs of the populations local systems are seeking to meet.
- While new, collaborative approaches between clinical commissioners and providers raise considerable opportunities to deliver efficient, high-quality care across a local system, it is essential that partners understand the legal basis of their decisions and take care to ensure they fulfil their respective duties. It is important to note that while this report explores the potential for CCGs to devolve activities to a lead provider or group of providers, CCGs cannot delegate their duties to such providers (Gov.uk, 2012).
- Where local systems have strong relationships, a focus on collaborative working is changing behaviours and prompting a shift in focus in how CCGs and providers relate to each other. With CCGs looking to perform a strategic commissioning function, some providers are adopting more responsibility for 'tactical' aspects of commissioning activity previously undertaken by NHS England or CCGs, such as redesigning pathways of care or introducing new services.
- Language is important. While contributors readily related to the concept of strategic commissioning based on population health management across a larger geography, few contributors understood the term 'tactical commissioning' which has been used in some national policy documents to describe the activities which could move from CCGs to providers in the context of system working.
- Though the evolution of the commissioner/provider relationship explored in this publication is not yet widespread or necessarily embedded in those areas discussing new ways of working, it is clear from the contributions to this report that commissioning is undergoing a process of significant change. This report includes case studies to provide systems with working examples which we hope will provoke local conversations and highlight early success factors.

Contributors identified the following key areas for systems to consider which can either enable or impede the evolution of local commissioning models:

- **Strong leadership**

The type of leadership required to drive forward system working is different from traditional leadership models that focus on leading individual organisations. Contributors highlighted the importance of:

- Collaborative leadership which is capable of transcending traditional organisational boundaries, and developing a shared vision and values across system partners. It takes time and continued concerted action to build the trust required to enable this.
- Clinical leadership across both commissioner and provider organisations. Clinically-led decision-making provides credibility and draws upon clinicians' close links to local populations. Putting clinicians at the heart of commissioning is a valued benefit of the 2012 Health and Social Care Act which helps to build public confidence in new models of care.

- **A 'bottom-up' approach**

Leaders in systems with more robust local relationships tended to welcome the permissiveness of the current policy environment in enabling them to develop new ways of working. Other contributors, often those in challenged health economies, sought more backing and a clearer sense of the national policy expectation around system working, including commissioner/provider relationships.

- **Involving all system partners**

Some contributors flagged the value of securing input from a wide range of organisations. Changes to local arrangements will need to consider the role of all organisations involved in the local commissioning and delivery of health and care, including local authorities and the voluntary and independent sectors.

- **One version of the truth**

Open book accounting, shared data and establishing 'one version of the truth', both in terms of the financial position and a shared evidence base, was seen as fundamental to collaborative working. The main barriers to achieving this were seen to be a lack of trust or shared purpose between partners and lack of confidence and insight in applying information governance requirements.

- **Supporting the workforce**

Contributors almost universally identified the importance of mobilising and flexing the local workforce over time in support of system working. The changing relationships between CCGs and providers also raise questions about whether providers may need additional capacity or new skills in-house to take on activities previously undertaken by a CCG. However, the severe workforce shortages facing the health and care sectors at the moment means that 'bandwidth' for changing ways of working is limited given the pressures staff face. Encouraging individuals who associate their employment with one organisation to consider themselves working for a place or population would additionally require a significant cultural shift.

- **Governance and accountability**

Contributors flagged the complexities of ensuring that robust governance mechanisms and clear lines of accountability underpin collaborative working within the existing legislative framework. This includes clear recognition of the different legal duties placed on commissioners and providers, and the fact that CCGs are accountable for commissioning for the outcomes and care of a population whereas provider boards remain accountable for the quality of the services they deliver.

- **Regulatory behaviour**

Many felt that detailed oversight and regulatory regimes, including the nature and volume of data requests from the national bodies, inhibits innovation and perpetuates the status quo. Contributors felt that there was a need in some parts of the country for more supportive behaviours from the centre, and to ensure the oversight and regulatory frameworks for CCGs and providers align with expectations of local system working.

- **Contractual mechanisms**

Aligned incentives contracts and block contracts provide two mechanisms for commissioners and providers to reduce perverse incentives and balance system risk. However, putting in place a risk share is challenging and some contributors felt that their local system did not have the capacity or relationships in place to support this approach at the current time.

- **Previous system failures**

Deep-seated challenges within a local system and previous organisational failures understandably often lead to a return to a 'fortress mentality' where attention focuses on individual organisational performance. Some urged systems to make use of these crisis points to rebuild relationships and drive innovation.

- **Legislation**

Some contributors felt that the current legislative framework, with its emphasis on competition and a strict purchaser/provider split, is prohibitive and deters local partners from developing new commissioning models and ways of working. Others held the view that where there is a clear case for change, and where relationships between local partner organisations are strong, legislation is not a barrier.

INTRODUCTION

Policy context

Despite the lack of legislative change since the 2012 Health and Social Care Act, the commissioning landscape is evolving at pace and increasing emphasis is being placed on collaboration over competition by both national and local NHS leaders. Within STPs and ICSs, clinical commissioners and providers are reflecting this as they look to work in different, more collaborative ways to deliver the best outcomes for their local populations, independent of organisational boundaries.

CCGs are coming together across larger geographical footprints. Arrangements include formal mergers, shared appointments and management teams, establishing committees in common, or commissioning on another CCG's behalf. CCGs are also increasingly working in close collaboration with their local authority commissioners, sometimes merging their respective commissioning teams.

NHS England has been considering how to ensure it works closely with CCGs and networks of providers to devolve responsibilities for developing and delivering specialised services and to adopt a more 'place-based' approach. This work is proving successful in pilots which devolve responsibilities for specialised mental health services to networks of providers across a larger geography, for example.

Providers are likewise continuing to develop new ways of working, adopting a variety of integrated care models. Some are looking to become integrated care providers or enter into integrated care partnerships, either through alliance or prime provider arrangements, while others are looking at horizontal forms of integration, for example through group models.

The relationship between clinical commissioners and providers therefore seems on the brink of significant change, with commissioners taking a more high-level, strategic approach, and providers taking on or supporting some more tactical or transactional aspects of the activities previously undertaken by CCGs. With this change, clinical commissioners could focus on working to assess population health needs and forecast demand, planning the nature, range and quality of future services and defining and contracting for outcomes. They would act as the 'stewards' of the system, but critically would need to have a strong relationship with providers and a real sense of ownership about what needs to happen across a system. Individual providers, or an alliance of providers, could in turn take over or support some functions that they would arguably be better placed to execute at a more local level. This could include:

- setting service specifications
- contract management
- resource allocation
- combining the management of current provider cost improvement programmes (CIPs) with commissioner quality, innovation, productivity and prevention (QIPP) efforts
- care coordination
- sub-contracting arrangements.

CCGs would retain statutory responsibility for all these functions, for as long as legislation as per the 2012 Health and Social Care Act stands.

This report is therefore intended to provide a timely contribution to the debate about how commissioning models and commissioner/provider relationships can best evolve to support local populations.

Report aims and methodology

To shine a light on the evolving commissioning landscape, NHSCC and NHS Providers jointly commissioned a piece of research in the summer of 2018. The purpose of this project was to showcase practical examples of collaborative working between CCGs and providers and to explore the current commissioning landscape in the context of system working, including moves to redefine the relationship between clinical commissioners and providers.

This research builds on *Steering towards strategic commissioning* (NHS Clinical Commissioners, 2017). The infographic and accompanying report on emerging commissioning models found that CCGs are evolving at pace, with a view to developing as a vehicle for a more strategic commissioning function. We return to this topic over a year later to review the current status of commissioning arrangements across systems and to explore the vital and changing role of providers within this context.

Underpinned by a literature review of relevant source materials, a number of in-depth, semi-structured interviews with both clinical commissioning and provider leaders were undertaken to gain an understanding of system working across local areas in England, supplemented by interviews with several national thought leaders. For further reading on this topic please see Appendix A and for a list of interviewees, please see Appendix B. A half-day roundtable event was also held to gain further understanding of system working across local areas – this was discursive and allowed for organic exploration of the topic. A list of roundtable participants can be found in Appendix C. NHS Providers and NHSCC are very grateful for the time and insight offered by everyone who helped inform this report – it would not have been possible without them.

In the context of system working, we are conscious that local commissioning arrangements will need to consider the role of all organisations involved in the local delivery of health and care, including local authorities, and the voluntary and independent sectors. However, this piece of research deliberately focuses on our core areas of expertise: the CCG/NHS provider relationship and the learning from the recent devolvement of specialised commissioning responsibilities to more local levels.

COMMISSIONING ARRANGEMENTS

Varied local progress

In most places, changes in how commissioners and providers are working together are still an ambition and not quite a reality. This is reflected in the nature of this report, which provides a snapshot of current working and thinking among local leaders.

It is also worth remembering that systems are developing at different paces across the country, often managing distinct local challenges. Differential process is also seen across service areas. For example, considerable progress has been made in tertiary mental health services, where a lead provider has taken greater responsibility for developing pathways across regional networks of providers on behalf of NHS England, the responsible commissioner. Overall, it is clear that there is no single model that will work everywhere and systems need to be supported to work at different paces.

Shifting language

Some systems have moved on from talking about commissioning, and instead use a vocabulary of system and place to describe new and more collaborative ways of working. One CCG chief officer and ICS lead said: “We don’t even like talking about commissioning now. I always say on the patch: ‘don’t use the c-word.’ It doesn’t add anything. We’re a group of leaders and we should be together looking at quality and money and improvements. That’s what matters.” Another CCG chief officer and ICS lead echoed this, noting that they no longer approach issues through the commissioner/provider relationship but look at the problem within that place, and then ask: “How can we take it forward? Who can contribute to the solution?” As a result, conversations are now much more transparent.



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CCG AND ICS LEADER

Other systems, partly in recognition of the fact that commissioning is the legally current term for a set of defined functions and activities, still use the term locally, while signalling an evolution of what it means and stands for.

It was clear that while contributors easily related to the concept of ‘strategic commissioning’, the language of ‘tactical commissioning’ (occasionally used in national policy documents to reference those activities which could be devolved from CCGs to a provider) did not resonate with anyone. In fact, contributors continually had to define those activities which might move to a provider, or providers, in the context of strategic commissioning.

The evolution of strategic commissioning

One thought leader drew on examples from other high-income countries with a purchaser/provider split. They thought a future strategic commissioner might focus on 'setting the system rules' such as specifying a 'care guarantee' with a prospective patient's specific right to access and care standards, and regulating decisions, for example "so as not to squeeze out the voluntary sector and to control monopolistic behaviours." Commissioners' overarching focus would then be on agreeing priorities, focusing on patient experience and outcomes, population health management, and governance of tax payers' money.

This vision may still be some way off, but some local areas, for example Surrey Heartlands, described how they had commissioned an external review to recommend how commissioning could evolve locally. This found that strategic commissioning functions and activities taking place either at ICS level or for the whole of Surrey Heartlands might include:

- business intelligence
- public health
- population health management
- digital strategies
- some procurement
- some clinical leadership development
- broad outcomes setting
- resource allocation
- assurance.

Providers would then take over a number of the activities that CCGs currently carry out, for example pathway specification and redesign. Providers are arguably better placed than most commissioners to undertake such work and relaxing the service specifications that some commissioners set for providers would enable providers to innovate in the interest of outcomes over processes. Several commissioner and provider leaders noted that this would be welcome to reduce wasting valuable management time and resource on non-value adding contract discussions.

One CCG chief clinical officer and ICS lead described how integrated care partnerships may become "provider entities" that are likely to take on local planning of services, quality assurance and improvement, service redesign, and pathway redesign. Some commissioning activities are thus being brought together at a partnership level, with others carried out at place and neighbourhood levels, with a detailed commissioning framework setting out how this will work. More formalised and statutory commissioning functions such as the allocation of budgets and formal consultation may be carried out across a bigger geographical footprint at ICS level.

A number of clinical commissioners see strategic commissioning as the future destination for CCGs – primarily defined as the ‘payor’ function in a health and care system, clinically-led, operating at a scale larger than a current CCG footprint, and recognisably accountable to the local population. If strategic commissioning is ‘the what’, this would allow a lead provider, or a group of providers to lead on ‘the how’.

Almost all contributors recognised a need for different commissioning footprints for different types of services. A number of contributors were clear that CCGs were undergoing a change process, whereby they were likely to become leaner and more strategic, and most thought this was appropriate for the current policy landscape and direction of travel. Several contributors specifically highlighted the importance of maintaining local autonomy and flexibility, and the need to balance that with the ‘bigger picture’ strategic approach that was recognised as necessary for effective population health management. Some suggested that provider partnerships as well as emerging forms of primary care provision (such as primary care homes, primary care networks and other models of primary care at scale) might be the new locus for truly locally grounded health and care partnership working.

One leader emphasised the importance of bottom-up leadership from GPs, stating: “We mustn’t lose the deeper understanding of local issues and the engagement with GPs locally that has been a real benefit of CCGs.” Beyond engagement, the importance of clinical leadership is also seen in the ability of clinical leaders across both commissioner and provider organisations to own and drive the local agenda and change needed, irrespective of the level that commissioning operates at.



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TRUST LEADER

ENABLING COLLABORATION

Leadership

The leadership style and skills required to drive and deliver system-wide change is different from what most current leaders have grown up with. NHS leaders are used to sitting on different sides of the commissioner/provider divide, with conversations traditionally based on negotiation. The changing commissioner/provider relationship will require a different sort of leadership and in light of this some contributors called for more national support for current and emerging system leaders.

Local systems are working to develop their own leaders. One contributor is looking to appoint a single joint accountable officer for both CCG and provider organisations. In Frimley a joint finance director already sits on the trust board but still holds an honorary contract with the local CCG arrangement. Others have taken a different approach to STP and ICS leadership development, such as the *100 system leaders'* scheme, a system-wide organisational development initiative in Lancashire and South Cumbria ICS, which brings clinicians and managers together on one leadership programme.

Leaders from some advanced systems described what they saw as critical aspects of leadership on a system basis:

- Developing a shared vision and agreeing priorities, and then taking people with you – doing so by changing mindsets rather than “telling people what to do”.
- Facing disagreement and different points of views upfront and not shying away from difficult conversations. One leader noted: “We have lived through some really difficult conversations together, but without making it personal – and this has built trust. We trust each other, even if we don’t always agree.”
- Trust was consistently identified as the key building block, with several contributors citing the dictum “our progress moves at the speed of trust”.



Our progress moves at the speed of trust.

TRUST AND CCG LEADERS

In terms of how people had managed to build trust and develop collaborative working, some leaders highlighted that:

- There are no shortcuts: doing this kind of work takes time, and a lot of it. One leader said: “You have to put the time in. You need to open up about your own challenges and what’s hard for you... We all own the problem; and we all own the solutions.”
- It can be very helpful to have honest conversations in facilitated spaces: external and objective facilitation can enable difficult things to be said and heard.
- Leaders should be clear and explicit about their commitment to and expectation that others will have the same commitment to:
 - the shared task at hand
 - building trust and relationships
 - ensuring that organisational boundaries will not be a blocker.

- Including all system partners: a good starting point is to engage clinicians with a clear vision, keep patients involved throughout the journey and include social care from the start. These are critical building blocks – they should not be add-ons.
- Organisations also need conflict resolution mechanisms agreed upfront for the rare occasions that joint positions do not work out.



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CCG AND ICS LEADER

Clinical leadership

There was broad consensus that clinical input and leadership are necessary to drive constructive local change, however contributors also acknowledged variation in the extent to which local systems had developed these key enablers of change. Some interviewees noted that clinical leadership hadn't really been put front and centre of their local integration initiatives, but instead seemed an after-thought. Others reported the opposite – namely that the local vision had been co-designed with clinicians who as a consequence acted as project champions for the proposed changes.

A frequently expressed view was that people were concerned to maintain and not to dilute the centrality of clinical leadership introduced with the reforms of the 2012 Health and Social Care Act. Clinical engagement and leadership were believed to be central both for rethinking and redefining patient pathways, and for leading and promoting change with the public. As one interviewee noted: "Without clinical leadership, you have zero credibility."



Without clinical leadership, you have zero credibility.

TRUST LEADER

Relationships and engagement

When probing more deeply into the centrality of strong relationships and engagement in successful system working, some key findings emerged:

- Engagement with patients and the public must be valued. Several contributors noted that genuinely engaging with local people could engender unexpected and positive results, with fresh ideas and a willingness to entertain change. Leaders overwhelmingly recommended early engagement with patients and communities as a must-do part of any pathway redesign work and in the formulation of population-based outcomes for an area.
- Getting GPs 'on board' and drawing on their rich understanding of local need and proximity to local communities was seen as a critical step that needed to be taken early in the journey. As secondary care providers take on more of the planning and designing of place-based healthcare, they are well positioned to partner with primary care and support its delivery. A few areas described how either the local CCG or acute provider had helped GPs federate or form an alliance, in the belief that strong and cohesive general practice was the critical cornerstone to further development. Others related how their local acute trust was supporting general practice to address prescribing overspend and an over-reliance on high-cost drugs by sharing its own learning and expertise.
- The importance of close working relationships with the local authority was highlighted by many, while also recognising that the political aspects of a local authority can seem alien to NHS leaders. One thought leader noted that the NHS often learns from local government's capacity for change, as most local authorities have a long-standing track record of significant organisational, social and economic changes. A couple of providers noted some tension with their local authority between their own pathway-centred approach, and the local authority's place-based approach but also acknowledged that this need not be a negative tension as it could generate constructive learning on both sides.

CASE STUDY 1

CCG and local authority relationship in Luton

Context

Luton CCG is part of the Bedfordshire, Luton and Milton Keynes (BLMK) Wave One ICS, currently operating as a shadow ICS. The three CCGs share a joint accountable officer and joint chief financial officer and are progressing well with recruitment to their newly-formed joint executive team.

Progress

In addition to working 'at scale', there is a clear focus in BLMK on transformation 'at place'. In Luton, a key strength of local commissioning is the CCG's strong relationship with the local authority. A milestone in this relationship was the signing of the *Luton health and wellbeing concordat* in June 2017. This statement of intent sets out the ambition to align strategic health and wellbeing commissioning functions through closer collaboration, integrated working and co-commissioning arrangements.

Pooled and aligned budgets are being used in commissioning services designed around the needs of Luton's residents rather than adhering to traditional commissioning silos. The CCG and local authority co-designed and procured the integrated wellbeing service *Total wellbeing Luton*, bringing together social prescribing, healthy lifestyle services and improved access to psychological therapies (IAPT) into a single point of access. Service users are holistically assessed and provided with support to meet their varied needs, whether they require debt advice, social support, weight management services, talking therapy, or all of the above. Personalised health and care planning and, where appropriate, personalised health and care budgets, are another area where focus has changed and new ways of working through integrated teams has benefitted the local population.

Progress has been enabled by mature local relationships and hard-earned trust between people at all levels in the organisations. These have been built over time and have been aided by stable leadership and a shared vision, centred on the aspiration of improving the lives of Luton residents.

The CCG and local authority are scheduled to move into shared premises in December 2018. Although co-location is not essential for collaboration, sharing the same working environment should remove some of the more practical barriers to integrated working and help further strengthen relationships between CCG and local authority colleagues. This should facilitate closer working and is expected to be a key enabler in accelerating Luton's journey of place-based transformation.

Workforce

If commissioners and providers are to undertake new functions and roles, they must have access to the skills and expertise to deliver them. Having a workforce with the right skills and capabilities, in addition to simply having enough people to safely deliver care, is a top priority and a growing challenge. Almost all contributors reported the difficulty of filling vacancies, and some referred to the specific impacts of Brexit, with additional worries about what the future might bring. New expertise is also sought – with clinical commissioners focusing on population health management, actuarial and modelling skills come to the fore, while providers may need different expertise and additional capacity in information analysis, sub-contract monitoring and supply chain management.

Sharing resources

Almost all contributors reported difficulties in attracting staff with the required skills. A leader in a challenged area described the dawning realisation that there wasn't enough money or staff in the local health economy. This meant that organisations increasingly pooled resources and functions to make best use of scarce capacity and to avoid duplication and waste. This included joined-up recruitment drives across the whole patch and deploying staff differently, for example staff with strong project management skills being placed at the heart of the system, independent of home organisations. Another example comes from Gloucestershire, where all staff in the CCG and approximately 160 staff in the local authority now have 'dual citizen' status, meaning they can work in either place and have access to the same electronic network.

Leaders within commissioner and provider organisations also spoke of working together on joint projects. This could also involve establishing joint HR, IT and other back office systems which save money for the overall health economy. Access to one electronic network was named a key enabler by several contributors who described co-locating local teams with access to the same IT systems so that people "stop seeing each other as different organisations and start seeing the patient."

The transfer of staff between CCGs and providers

Contributors recognised that providers may need additional capacity and new skills in-house if over time they are to take on additional activities currently undertaken by CCGs. Few systems were at the stage of planning for this, however there are some that have successfully transferred staff between commissioners and providers. In one example a CCG embedded some of its staff within the provider, with a memorandum of understanding and management agreement in place, however there remained difficulties in aligning organisational cultures. It is clear that embedding or transferring staff between organisations is a significant task and will require a lot of planning and engagement with staff, which will likely work better in areas with mature infrastructure and strong relationships.

CASE STUDY 2

Resource sharing in Devon Partnership

Context

Since April 2017 Devon Partnership NHS Trust has been part of the new care models tertiary mental health services programme. The trust is the accountable provider leading a partnership of eight organisations across the south west to commission and provide adult medium and low secure mental health services. This is delivered across 22,000 square kilometers, covering a population of five million, within a budget of around £71m.

Progress

A formal delegated accountability structure is in place – all eight partners contribute to the clinical design, and are represented on a partnership board, alongside NHS England who retain statutory accountability for the commissioning of services. A five-year clinical model and business plan has been agreed through the partnership board, and a financial gain and risk share is in place across four of the eight partners. Some NHS England staff and functions are embedded within Devon Partnership NHS Trust, supported by a management agreement.

The partnership has been successful in reducing out of area placements, bringing around 85 people back into the south west region for treatment.

Identity

There was a clear interest in using the development of system working to create opportunities to review workforce planning, to develop new, attractive and flexible roles to recruit and retain talented individuals into the service, and to ensure that skills can be deployed across a wider footprint in the optimum way.

Contributors were keen to develop a new system wide culture in which staff felt comfortable with “working for a place rather than an organisation.” Several acknowledged the challenging nature of this ambition, citing the recognised need for people to belong to a specific group or team, and the importance of organisational affiliation. At the same time, it’s clear that there are developments underway in this direction. An ICS lead referenced everyone on the patch recognising the need to jointly resource the transformation work of the ICS. In this system an agreed HR framework enables staff to move between roles on the patch to where their skills are most needed, without a change in employment status. Similar arrangements are in place in other systems, allowing staff to take secondments across commissioner and provider organisations.

Others described an increasing number of joint appointments across the wider patch, as well as people working in 'virtual teams', for example, comprised of staff in community care, acute care and social care forming cross-organisational teams.

Financial and contractual arrangements

Several contributors noted that new contractual forms have been the vehicle for formalising a local commitment to working differently together as commissioners and providers. In other systems, traditional procurement mechanisms, normally viewed as a pillar of the competition agenda, have driven provider collaboration and local health planning.

Contractual arrangements

Many contributors pointed to the impact of current tariffs and payment systems, often felt to incentivise acute episodes of care, rather than focusing on outcomes along pathways of care. Some gave examples of how they have therefore tried to move away from the tariff as a contractual unit of measurement.

A form of block contract was the most commonly reported contract model, with several contributors describing a block contract, with an agreed risk-share, in place for 2018/19. Several interviewees reported that this was working well, while one person felt this was a "retrograde step" that had resulted in more emergency demand in the system and "far more inappropriate referrals from GPs." One person described the risk-share arrangement as the hardest thing to agree on the patch, and another said that the whole integration effort is "primarily about managing risk, trying to situate the risk with the organisation/s most able to mitigate it, and giving them the power to do so." Both providers and commissioners noted that the volume utilisation risks under a block contract tend to sit entirely with providers. One leader commented that this could only be adequately mitigated by a built-in risk share underpinned by a detailed population health understanding and risk stratification. Some interviewees felt that their local system did not have the capability or knowledge to effectively manage risks and called for support on how to do this well.

One system leader described a close collaboration between the three acute trusts, the CCG, and the mental health provider on the patch, underpinned by a two-year block contract. The system had suspended the national tariff payments system and partners addressed their system control total by moving money between organisations to ensure the receipt of transformation funding.

Several interviewees described using a different kind of contract, such as an aligned incentives contract. In this approach, one set of priorities for the year was agreed between all parties, with an associated risk pool and a systematic programme of work across commissioners and providers agreed to avoid duplicating other improvement efforts (such as CIPs and the QIPP programme). This approach was felt to have led to much more sensible and constructive conversations and strengthened relationships locally, compared to the old

style, non-value adding way of transactional contracting. One leader noted: “It’s the best way of getting skin in the game from all parties, using different forms of risk sharing.” An acute leader described how approximately 75% of their contracts with commissioners were based on this type of contract, and how this had been very positive in terms of getting the right focus on outcomes and eschewing polarising and time-consuming contract meetings. This had also reduced the costs of the contracting teams and therefore saved money for the overall system.



[The whole integration effort is] primarily about managing risk, trying to situate the risk with the organisation/s most able to mitigate it, and giving them the power to do so.

CCG LEADER

CASE STUDY 3

Aligned incentives contracts in Bolton

Context

The national tariff arrangements between Bolton CCG and Bolton Foundation Trust were creating tensions, with continued disputes over counting, coding and payments. Both the CCG and provider agreed to find a more productive and collaborative way of working to manage system costs.

Progress

CCG and foundation trust executives agreed contracts and payments needed to be simpler. In place of the traditional national tariff payment system, Bolton designed a new aligned incentive contract which fundamentally shifts the focus from tariff prices to cost. This approach is based on six key principles:

- deficit of either trust or CCG is a failure of both
- collaborative working
- aligned incentives
- open, transparent conversations with no fear
- enabling and supporting the vision of the local system
- risks faced, shared and managed.

The contract has now been adopted by others and has won a Healthcare Financial Management Association award. The CCG and the trust believe that the new way of working removes barriers to transforming services and reducing costs, with both organisations working on joint projects under collaborative arrangements.

Procurement

In some systems CCG procurement was seen as vital for provider collaboration, requiring providers to plan and design healthcare as part of a bidding process. In Dorset for example, the CCG put urgent and emergency care out to tender (including NHS 111 and advisory services, GP access and urgent care). As a result, several NHS providers entered a formal collaboration and drew up plans for the local system. This plan was submitted to the CCG as a bid and the provider consortium was successful in winning the contract.

In Hillingdon, a similar tendering process took place for musculoskeletal (MSK) services. The provider alliance partnered with its local Academic Health Science Network to assess the local population's needs, review MSK service configurations elsewhere in the country and ultimately produce a credible plan for Hillingdon CCG.

In other situations, some noted procurement can be less of a facilitator to integration as it means that CCGs are inclined to put contracts out to tender when this is not always necessary, causing delays and undermining system working.

Establishing one version of the truth

The majority of contributors spoke about the importance of a shared source of information and intelligence to underpin collaborative efforts.

A shared vision

In line with the general focus on the importance of strong and trusting local relationships, several contributors mentioned the challenge of bringing about one shared vision, with an accompanying strategic plan and a roadmap for how to get there. One hospital-based leader outlined the key questions used in their system to guide both commissioners and providers:

- 1 What is the goal?
- 2 What care model do we need in our system, and what are the care interactions (including self-care and IT-based care)?
- 3 What does the system architecture need to look like to deliver the care model?
- 4 What functions are needed to do this?
- 5 What contractual arrangements lock together these components while remaining consistent with the regulatory and policy frameworks?

Open book accounting

Having one version of truth about the financial position was seen as a critical step towards being able to take on a system control total, and many contributors described an intention

to move towards open book accounting between system partners. It is acknowledged, however, that this was a very difficult thing to affect, mainly due to “the ingrained culture of a competitive, siloed approach to contracting.” This is reflected in the perception of several interviewees who felt that all system partners in their patch still hold some information back.

It is clear that achieving complete openness about finances runs counter to the many years of competition and the culture of individual organisational responsibility in which most NHS managers have spent their working careers. Despite this, there were some areas, such as Berkshire, which reported having made the move to open book accounting, explaining that it worked well and solidified their system approach to driving change.

Shared data

The absence of good and meaningful shared datasets in many local systems was noted as a strong impediment to change, with widely shared, reliable data, and the digital readiness to share that data appropriately, cited as key conditions both for establishing collaboration and effective planning based on trust. There were examples of a strong local commitment to achieving one version of the truth – Dorset, for instance, described what they called “360 degrees transparency” with regard to money, workforce and quality. A local authority chief executive likewise spoke about the importance of everyone “getting the same information, at the same time” and how this was becoming a reality in their place-based board.

Governance and accountability

Systems have developed different governance mechanisms to underpin collaboration between organisations in the context of system working and to ensure clear lines of accountability to the public, regulators and national bodies. Establishing robust governance arrangements to support system working and manage risk effectively was commonly seen as a challenge by local leaders, with some contributors highlighting a lack of national clarity and guidance on these issues.

Contributors emphasised the importance of building constructive and trusting working relationships between partner organisations, and developing a shared sense of purpose as the foundation for collaborative arrangements.

Accountability and challenge

In order to ensure clear lines of accountability in the context of system working, it is important to recognise the respective duties and responsibilities of CCGs and providers for the patient populations they serve. One CCG leader noted that a CCG is population based but, for the most part, a provider, serves a smaller footprint and delivers particular services within that population. This “subtle but important difference” should be considered when it comes to governance and public accountability. In the context of system working

it is important to maintain clear lines of public accountability, and to be clear that even in the most advanced systems, within the current landscape, a distinction between the responsibilities of the component organisations within an ICS/STP, and between commissioners and providers, still exists.

Contributors also highlighted the importance of building lay and non-executive challenge into the development and assurance of system-wide plans. This is difficult to deliver within the current legislative and governance frameworks, however some contributors had taken steps towards this end in developing reference groups involving CCG lay governing body representatives, patient representatives, trust non-executive directors and councillors in complement to CCGs' and providers' own processes for challenge and accountability. Contributors also emphasised the need to ensure that existing organisational structures (CCG governing bodies and trust boards) contributed to assuring system-wide plans, given that the responsibility for decision-making still rests in individual organisations at the current time.

Decision-making

Some contributors reflected on where decision-making should best take place within the context of system working. For example, one trust chief executive suggested that around 80% of decisions should be made at place level – close to those both delivering and receiving services, and 20% should be taken at the wider system level (Kershaw, 2018).

The value of strong clinical involvement in decision-making processes was also recognised. Several places have established, or are establishing, a clinical reference group (CRG) to ensure this is built into the system from the start. The CRG is typically constituted by a wide range of clinicians and allied health professionals from primary care, community care, social care and acute care. Any decisions impacting on patient care or users of services, such as proposed pathway changes or redesigns, go to the CRG for agreement. In some instances, the CRG is constituted so that it can take on decisions formerly taken by the CCG, so that while the CCG is still formally and legally accountable, they are in practice simply ratifying the decision of the CRG. One leader described it as “locating decision-making as close as we can to the clinical coalface.”

Finally, contributors recognised the need to manage conflicts of interest within the context of system working – and to ensure robust processes, including for conflict resolution between partners, were in place.



*Locating decision-making as close as we can to the clinical coalface,
with very strong clinical input.*

TRUST LEADER

AREAS OF DIVIDED OPINION

While commissioners' and providers' views on success factors and barriers to system working were fairly unanimous, there were three areas where opinion was divided.

Changing legislation

Current legislation, with its emphasis on competition over collaboration, and its strict dividing line between commissioners and providers, was cited by some contributors as an insurmountable obstacle to real change. Those who saw the situation this way felt that the role of CCGs would be unlikely to change until there is new legislation: "the expectation amongst everyone is that very soon, there will be a much smaller formal commissioner, but our CCGs are not acting any differently, and are clear that they won't, until their statutory role has formally changed." The majority of those interviewed however held a different opinion, namely that the current legislative framework offers sufficient flexibility to facilitate meaningful change. One leader stated: "I keep saying: lean into the future and behave as though we've had new legislation and are one organisation."



I keep saying: lean into the future and behave as though we've had new legislation and are one organisation.

CCG AND ICS LEADER



Our CCGs are not acting any differently, and are clear that they won't, until their statutory role has formally changed.

TRUST LEADER

What accounts for this difference in views? One explanation is that fear and uncertainty about the future – both for organisations and individuals – contributes to commissioners strictly upholding the traditional role of the CCG. In addition, areas with a history of collaboration and strong relationships seem less likely to encounter this issue, suggesting that here too, trust and strong relationships ease the path of change. Whichever view is taken, it is clear that CCGs and providers have to comply with the law as it stands.

Impact of previous failures

The second area of divided opinion was the impact of previous system failures. Across STPs and ICSs, there are areas facing deep-seated challenges with legacy issues around finance, quality and/or access. Ultimately as systems look to trail-blaze new commissioning arrangements, there is a risk of organisations 'getting their fingers burned'.

A couple of interviewees described how a legacy of challenges has led to a break-down in trust and dialogue and an entrenchment of organisational "fortress mentalities". In this context, each statutory organisation looks after their own interests and bottom line, and a more integrated approach seems doomed: "We have a board with all the right people on, and everyone is supposedly neutral when in the room together; but in reality everyone is

in it for themselves and pushing their own organisational agenda.” In such cases, there was much time and effort spent on activities like contract disputes and delineating each organisation’s respective statutory duties.



Keep things safe and quiet now, to avoid unwanted national attention.

TRUST LEADER

Providers in Cambridgeshire and Peterborough described a situation where, feeling badly burned, the system is reverting back to traditional, transactional contracting with a sense among both managers and clinicians to “keep things safe and quiet now, to avoid unwanted national attention.” There is a worry that this effect may be long-lasting, even though there is a local belief that the principles behind the initiative were absolutely right: the sharing of budgets, and the bringing together of hospital and community teams. While there are small-scale integration work and pilots now under way, for example joint education sessions and ambulatory care, there is no appetite for large scale pilots or initiatives.

Several leaders, however, described the opposite – the challenges of their local systems meant that all organisations had come together in the realisation that they “were out of road, and had to do things very differently or go under.” Another leader said: “Don’t waste a good crisis. It has made us braver and bolder... we’d rather take control of our own destiny than ‘be done to.’” It therefore seems as though deep-seated and system-wide challenges, whether concerning money, quality, access targets, or some combination thereof, can either make the transformation and integration journey that much harder, or it can serve as a perverse kind of enabler of that journey.



Don’t waste a good crisis. It has made us braver and bolder...

CCG LEADER

Similarly, in Hillingdon, an initial failure led to a more positive set of developments. The local system had initially wanted to establish a capitated budget for the integrated care partnership to manage and was in the process of designing the appropriate governance and financial structures. This task proved too ambitious and all parties considered the risk too big but instead of reverting back to old ways of working, the commissioner and providers identified system priorities and targeted more achievable changes.

CASE STUDY 4

Adopting a pragmatic approach in Hillingdon

Context

Hillingdon lies at the edge of the North West London STP. Providers, operating under an integrated alliance called Hillingdon Health and Care Partners, and the CCG have started to move towards a 'joint implementation' model in which the providers take responsibility for reorganising services, while the CCGs act as 'stewards', and manage resource transfers.

Progress

The providers and the CCG had initially looked to establish a capitated budget, along with appropriate governance structures. It was soon determined that setting up this structure would create a significant amount of risk and so the plans were abandoned. Nevertheless, there remained an appetite for collaboration between the CCG and providers. An alternative and more pragmatic approach was eventually adopted. This focused on individual pathways, with the CCG setting out 'the challenge' (including desired outcomes), and the providers developing a business model. The model was initially used for MSK services in Hillingdon and is now being applied to ophthalmology. It is underpinned by open and shared planning and regular challenge from both sides.

What determines whether a system reverts to a more traditional, risk-averse and siloed way of working, or takes another step forward and tries again? Again, the strength and history of local collaboration and the quality and longevity of relationships, as well as the tone set by local leaders, all factor in. Another factor appears to be the degree to which a local system, or local leaders, felt singled out and subjected to criticism by the centre or in the media. Not surprisingly, such an experience is likely to inhibit future risk appetite and possibly undermine existing relations.

The impact of policies and behaviours of national bodies

Contributors varied greatly in their views of the degree to which the centre (NHS England, NHS Improvement and other arm's-length bodies) was helpful in facilitating collaborative working. There was a shared view of the significant burden of what was felt to be excessive data requests and demands for information, sometimes at very short notice. Many also felt that the current assurance regime was excessive as well as poorly joined-up between system partners, and that regulatory frameworks were lagging behind developments on the ground.

People were split between those who felt that the permissive policy landscape, where many kinds of models and initiatives could be trialled, was a positive thing which encouraged local problem-solving, innovation and bespoke solutions, and those who believed that the lack of a central implementation plan meant that a huge amount of time, effort and public money was being spent “reinventing the wheel.” One chief executive called for a roadmap from the centre to cut out duplication of effort and wasteful spend on legal costs. Others gave the advice: “Don’t wait for permission from the centre or for being given formal ICS status – just go ahead with the work and with the necessary change!”



Don't wait for permission from the centre or for being given formal ICS status – just go ahead with the work and with the necessary change!

CCG LEADER

Support and oversight

The majority of contributors felt that the burden of reporting to the centre was excessive, and some reported that it ate up so much resource that the job of making things happen locally suffered. Many said that NHS England and NHS Improvement were not as helpful as they could be and described demanding and inflexible management behaviours. One interviewee reported a deep fatigue with the centre and the national system, and especially commented on how the organisation felt “fed up with NHS England policy and changes and being told what to do.”

Especially challenged health economies found the national bodies’ interventions counterproductive and an additional burden and hindrance rather than a help. One interviewee felt that “they keep pulling up the plant to check its roots” and suggested that a more productive way forward would be for the centre to help the challenged health economy develop a three to five year programme of improvement.



They keep pulling up the plant to check its roots.

TRUST LEADER

There were notable exceptions to this, with one leader describing a “very positive journey with the national NHS England team” comprised of constructive, tailored help and support. In particular, this local system felt that the national team were “rooting for them” and trying to bend rules and requirements so as to support local plans and initiatives, and that they had the confidence and trust of the centre to ‘get on with it’, without having to explain their every move. By contrast, at the regional level they found their local NHS England team rigid, inflexible and disinterested in offering constructive support, focusing on detailed assurance instead of the bigger picture.

Regulation

Many contributors noted that regulation tended to privilege the status quo over innovation, and was lagging behind actual developments on the ground, with current regulation focusing on individual statutory organisations rather than system working. This was felt to be a counter-productive way of working that caused frustration, delay and poor use of resource. One chief executive reported how some “very unhelpful regulatory behaviour damaged relationships and set us back several months.” Some providers in more mature systems felt that NHS England behaved as a quasi-regulator which was not aligned to system working and there was a general criticism of ‘national ivory towers’ that are divorced from the realities of system working. Respondents were also critical of the mixed or inconsistent messages they have sometimes received from different national bodies. However, there was cautious optimism expressed about the national developments of bringing NHS England and NHS Improvement closer together.

Like national regulatory approaches, the current financial framework was seen as inhibiting collaboration by pulling CCGs and providers back into organisational silos. Both providers and commissioners would welcome a longer-term planning cycle to allow systems to focus more on outcomes-based planning. The existing units of measurements were felt to hamper taking a population-based approach.

A few contributors commented on how the rapidly shifting terminology and the centre’s changing ways of describing the ask of the system was confusing and often off-putting, especially for clinicians. One interviewee said: “We’re trying to ignore all that national noise and come up with our own story and our own plan that is de-coupled from all the national lingo.”

CONCLUSION

It is clear that diverse approaches are emerging across systems to reimagine the relationship between commissioners and providers. It is equally clear however that most of these developments are at an early stage and that there is no blueprint to work from.

Contributors to this report were unanimous in their view that the single most important driver of change was investing the time required to build strong relationships which would then underpin a tailored approach that works for their local population.

While there is no single best approach to deliver place-based commissioning, there are some key changes at the national level which could further enable providers and commissioners to collaborate more freely as system partners, in a way that supports the planning and delivery of care to best meet the needs of the populations they serve. These changes include:

- **Aligning national policy expectations with developments on the ground**
National regulation, financial incentives and assurance processes should align with the expectation that local organisations work collaboratively in systems.
- **Ensuring national behaviours mirror the expectations of local partnerships**
As CCGs and providers look to develop closer partnerships, colleagues in the national bodies should consistently adopt a similar approach in their day-to-day dealings with local bodies, offering constructive support to balance a focus on immediate challenges and the longer-term direction of travel for the system.
- **Offering national guidance and support to help systems navigate the new landscape**
Given the early stages of developing system working, some key areas of challenge have been identified, where both commissioners and providers would benefit from greater support or guidance. NHSCC and NHS Providers similarly recognise their role in offering additional support in these areas. Three key areas where national support is needed were highlighted:
 - Leadership support to develop collaborative and clinical leadership. New skills are required to effectively lead across a system, in particular to manage the challenges associated with working in pressured systems. Leadership programmes should emphasise the importance of clinical engagement across system and place.
 - Support to manage risk, accountability and governance. Many local systems would welcome support to develop robust governance arrangements that assist collaborative working, in line with their legal obligations. This support should reflect the varied needs of local contexts, including challenged systems.
 - Continuing to create opportunities to share innovative practice. As it emerges across the sector, good practice examples of system working should be shared to enable learning.

Alongside our call for national support, this report highlights key considerations for systems looking to drive forward system working.

Table 1
Supporting system working

Early success factors to support system working	Challenges to navigate
<p>Strong collaborative and clinical leadership</p> <p>Leadership must be capable of transcending traditional organisational boundaries and must remain clinically driven.</p>	<p>Contractual mechanisms</p> <p>Balancing system financial risk and the financial requirements placed on organisations remains a key barrier to collaborative working, particularly within challenged systems. Perverse incentives in the payment system also remain, though some areas are working to navigate this.</p>
<p>Establishing one version of the truth</p> <p>Having 'one version of the truth' – both in terms of the financial position and a shared evidence base is a key enabler of collaborative working. This can be facilitated through shared data sources and open-book accounting.</p>	<p>Governance and accountability</p> <p>Partners within systems need to ensure that robust governance mechanisms underpin collaborative working, with clear lines of accountability to the public for delivery.</p>
<p>Supporting the workforce</p> <p>There is a need to work with local staff over time to develop the flexibilities needed to support integrated working, for example through pooling resources or appointing joint posts.</p>	<p>Regulation</p> <p>Commissioners and providers have to fulfil the regulatory requirements of national bodies, which can often prove time-consuming and shift focus away from collaborative working. While areas of local progress are being made, national policy that is aligned to support new relationships between CCGs and providers would be welcomed.</p>
<p>Involving all system partners</p> <p>While this report focuses on relationships between clinical commissioners and providers, successfully integrated system working requires engagement of all system partners, including local authorities and the voluntary and independent sectors.</p>	<p>Previous system failures</p> <p>Deep-seated challenges within a local system and previous organisational failures can lead to a retreat from system thinking, with attention focusing on individual organisational performance.</p>

What is striking is the appetite for change right across the NHS. Both commissioners and providers recognise the need to do things differently to make best use of their collective resource, and to deliver the best possible outcomes for their patients and populations in the face of significant performance, financial and operational challenges. A pragmatic approach is emerging in many localities that is allowing commissioners and providers to find creative ways of working more collaboratively across system, place and neighbourhood footprints.

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APPENDIX A

Further reading

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APPENDIX B

List of interviewees

Providers

- Samantha Allen, Chief Executive, Sussex Partnership NHS Foundation Trust
- Nicola Ayton, Director of Strategy and Major Projects, Cambridge University Hospitals NHS Foundation Trust
- Charlotte Bailey, Executive Director of Strategic Partnerships, Birmingham and Solihull Mental Health NHS Foundation Trust
- Carl Bashford, Head of Service, Tees Esk and Wear Valleys NHS Foundation Trust
- Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust
- Mark Cubbon, Chief Executive, Portsmouth Hospitals NHS Trust
- Tim Guyler, Director of Integration, Nottingham University Hospitals NHS Trust
- Jim Mackey, Chief Executive, Northumbria Healthcare NHS Foundation Trust
- Jacqueline Myers, Director of Strategy and Planning, Hull and East Yorkshire Hospitals NHS Trust
- Keith Reynolds, Assistant Director of Strategy and Planning, North West Anglia NHS Foundation Trust

Commissioners

- Dr Amanda Doyle OBE, Lancashire and South Cumbria ICS Lead and Chief Clinical Officer, Blackpool and Fylde and Wyre CCGs
- Tim Goodson, Dorset ICS and STP Lead and Chief Officer, Dorset CCG
- Amanda Hume, Executive Lead for System Transformation and Strategic Commissioning Development (North East and North Cumbria)
- Mary Hutton, Gloucestershire ICS Lead and Accountable Officer, Gloucestershire CCG
- Matt Jukes, Chief Executive, Hull City Council
- Yvonne Rispin, Director of Ambulance/111 Commissioning (North West) and board member, Blackpool CCG
- John Stamp, Senior Commissioning Manager, North of England Commissioning Support
- Matthew Tait, Joint Accountable Officer, Surrey Heartlands CCGs
- Dr Cathy Winfield, Berkshire West ICS Lead and Chief Officer, Berkshire West CCG.

National thought leaders

- Paul Corrigan CBE, Independent Consultant and Coach, former Health Policy Adviser to Tony Blair and former Special Adviser to Alan Milburn and John Reid
- Ben Dyson, Executive Director of Strategy, NHS Improvement
- Nigel Edwards, Chief Executive, The Nuffield Trust
- Michael Macdonnell, National Director of Transforming Health Systems, NHS England
- Martin McShane, Chief Medical Officer Clinical Delivery, Optum International

We would also like to thank

- Matthew Kershaw, Chief Executive, Croydon Health Services NHS Trust
- Paul Maubach, Chief Accountable Officer, Dudley CCG and Walsall CCG
- Tracy Taylor, Chief Executive, Nottingham University Hospitals NHS Trust
- Annette Walker, Director of Finance, Bolton NHS Foundation Trust
- Simon Worthington, Director of Finance, Leeds Teaching NHS Trust

APPENDIX C

List of roundtable participants

Providers

- David Bradley, Chief Executive, South West London and St George's Mental Health NHS Trust
- Dominic Conlin, Director of Strategy and Business Development, Chelsea and Westminster NHS Foundation Trust
- Paul Farrimond, Non-executive Director, Barnet Enfield and Haringey Mental Health NHS Trust
- Dr Jason Fee, Clinical Lead New Care Models, Devon Partnership NHS Trust
- Nigel Foster, Director of Finance, Frimley Health Foundation Trust
- Anne Forbes, Programme Director New Care Models, Devon Partnership NHS Trust
- Dr Gordon Macmillan, Assistant Director of Strategy and Business Development, The Hillingdon Hospitals NHS Foundation Trust
- Sultan Mahmud, Director of Integration, The Royal Wolverhampton NHS Foundation Trust
- Sarah Morgan, Director of Organisational Development and Healthcare Alliance Director, Guys and St Thomas' NHS Foundation Trust
- James Underhay, Deputy Chief Executive and Director of Strategy and Development, South Central Ambulance Service NHS Trust
- William Wilkins, Associate Director of Strategy, Royal Berkshire NHS Foundation Trust

Commissioners

- Roundtable Chair: Dr Graham Jackson, Clinical Lead, Buckinghamshire ICS and Co-chair, NHSCC
- Dr Chirag Bakhai, GP and Deputy Clinical Chair, Luton CCG
- Henry Black, Chief Finance Officer, East London Health and Care Partnership and Joint Chair, NHSCC Finance Forum
- Chris Clark, Director of Commissioning, Brighton and Hove CCG
- Dr Anthony Kelly, Chair, South Worcestershire CCG
- Dr Phil Moore, Deputy Chair (Clinical), Kingston CCG and Chair, NHSCC Mental Health Commissioners Network
- Jason Stamp, Lay Member for Patient and Public Involvement, Hull CCG and Deputy Chair, NHSCC Lay Members Network
- Dr Josephine Sauvage, Chair, Islington CCG, Co-chair, North London Partnership Health and Care Cabinet and Chair, Haringey and Islington Wellbeing Partnership

NHS Clinical Commissioners and NHS Providers representatives

- Sara Bainbridge, Head of Policy and Delivery, NHSCC
- John Coutts, Policy Advisor (Governance), NHS Providers
- Miriam Deakin, Director of Policy and Strategy, NHS Providers
- Emily Jones, Senior Policy Officer, NHSCC
- Leanora Volpe, Policy Officer, NHS Providers
- Julie Wood, Chief Executive, NHSCC
- Adam Wright, Senior Policy Officer, NHS Providers

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Interactive version

This report is also available in a digitally interactive format via:
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