Investigating recent developments in the commissioning system

Final Report

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Background

The Health and Social Care Act 2012 (HSCA 2012) introduced major changes into the commissioning system for the English NHS in 2013. Primary Care Trusts (PCTs) were replaced with Clinical Commissioning Groups, clinically-led statutory bodies responsible for the planning and commissioning of health care services for their local area. A new arms-length body, NHS England (NHSE), was established with responsibility for overseeing the work of CCGs. Commissioning responsibilities for local populations are now divided between CCGs, local authorities and NHSE. Since the HSCA 2012 took effect, there have been several important policy developments, which affect the 'new commissioning system'. First, in 2014, *The Five Year Forward View* (5YFV) focussed on how organisations in the NHS need to cooperate with each other, and form new configurations known as 'new care models' (NCMs), the first wave of which have been designated 'Vanguards'. There are also other organisational and service delivery changes being implemented across the country, designed to improve the integration of care. These changes take a range of forms including both horizontal and vertical integration. In 2015, the relevant NHS national bodies issued a further policy document introducing the concept of local cooperative, place based planning, initially known as Sustainability and Transformation Plans and from March 2017 Sustainability and Transformation Partnerships (STPs). There are 44 STPs, almost all of which include several CCGs, and many of which include seven or eight. Therefore, it will be necessary for CCGs to work together to provide system leadership in their local economies, as well as find a way to work with local providers.

Despite these developments, there have been no relevant legislative changes, so the HSCA 2012 provisions concerning the respective roles of NHS commissioning organisations and the regulatory framework in respect of both procurement and provider competition remain in force. There is now a more complex local landscape of organisations all of which need to be involved in the planning of local services; and CCGs need to be able to find ways to engage with them effectively. This project investigated the initial stages of this process.

Aims

The questions addressed by the research were:

1. How are CCG internal processes of decision making changing?
2. What is the role of the individual CCG in the current commissioning landscape?
3. How is accountability maintained by CCGs in the current commissioning landscape?
4. How is competition and the current pricing regime relevant to CCGs' commissioning decisions?
5. How should commissioning develop?

Design and Methods

The design of the study consisted of three case study sites centred round three CCG areas, spread across England. Our main method of data collection was interviews with senior commissioners in the CCGs and senior managers in a selection of local provider organisations and local authorities. We collected additional data by examining locally produced documents, such as STP plans. Data collection took place between November 2017 and July 2018. Data analysis was conducted using a thematic analysis derived from the research questions.

Results

CCG internal processes of decision-making

CCGs' internal decision making processes had changed to a certain extent. There was some evidence that the CCG Governing Body (GB) was becoming more strategic. The daily issues confronted by CCG management had not changed greatly, centring on finance, quality and system recovery. CCG priorities were formulated at committees below the GB in some instances and these priorities were increasingly informed by partnership working.

Role of the individual CCG in the current commissioning landscape

CCGs were operating in an increasingly complex commissioning landscape. They were working with a wider range of local partners and had to exercise their statutory functions in the context of wider system working. This required moving beyond an organisational focus towards a system approach. Our case study CCGs were working jointly with neighbouring CCGs to streamline collective decision-making in order to reduce the need for individual CCG approval for every decision.

Thus, CCGs had new horizontal accountabilities to other commissioning organisations and local partners as well as traditional vertical accountabilities to the national regulator, CCG members and the public. Horizontal accountability proved challenging for all organisations. A key challenge was the delegation of decision-making powers to Boards and committees involved in collaborative working. This meant that a single leader or Board could not be held ultimately accountable. In response to this problem, mutual accountability arrangements were under development, whereby partners would undertake peer review and hold each other to account, reducing the need for intervention by an external regulator. The design of accountability arrangements was easier in systems with fewer organisations.

CCGs' upward accountability remained to NHSE, with increasing involvement of NHSI in the context of closer working between the regulators at a regional level. CCGs continued to engage GP members and the public through various events while also preparing GPs for a wider system role.

Development of STPs

A lack of statutory status limited the decision-making powers of STP structures. There was variability in the development of STP governance structures across the case study sites. CCG Accountable Officers took on the additional role of STP Lead in two of our case studies. One CCG had a history of working with organisations in a different STP footprint and the introduction of STPs made these relationships more difficult. Another problem in the early development of STPs was inadequate engagement of LAs. Incentives for CCGs and partner organisations to participate in STPs included transformation funding, shared control totals and CQUIN payments for providers. Coordination between the different initiatives was primarily achieved through the adoption of the principle of subsidiarity by the STP. Moreover, STPs tended to build on partners' existing governance structures and programmes of work.

STP partners did not view themselves as accountable to the STP due to its non-statutory nature. Primary accountabilities for organisations remained to the regulators, organisations' Boards and members and the public. There was some evidence that the national regulators treated STPs as if they had decision-making powers and viewed STP Leads as accountable for the performance of the STP. However, STP Leads had few levers to exercise over partners and relied primarily on personal relationships and peer influence.

Plans for local Integrated Care Systems

While the term 'ICS' was originally used to describe a system evolving from the STP footprint, interviewees applied the term to integrated working arrangements at many different levels or footprints. The ICS label was applied to initiatives at the CCG level (such as evolving MCP Vanguards), as well as the STP level. Alliance agreements underpinned these arrangements at the CCG level and a new organisational form to support integrated working was not anticipated. An important aspect of integrated services was the workforce and the significance of role, rather than employer organisation was stressed.

CCGs' use of commissioning levers

We explored the extent to which different commissioning levers such as competition and payment systems facilitated or impeded collaborative working. We found divergent views on competition between LA and NHS interviewees. LAs were in favour of competition as they faced dynamic local markets. In contrast, CCGs were in favour of moving away from competition, as they did not believe it was useful for facilitating integration and providers needed to collaborate to address system challenges. A common view among NHS commissioners and providers was that competition did not necessarily drive up quality or promote innovation and could lead to fragmentation of services.

Some CCGs used the competitive dialogue procedure to procure innovative contracts such as alliance and lead provider contracts to facilitate integrated working. Negotiation of such contracts was difficult due to the need for cost-savings. These contracts often involved shifts in activity between organisations and interviewees expressed a willingness to reduce their activity and income for the benefit of the system. Nevertheless, there was some evidence of competition for services between providers, which could impede alliance working.

There was a consensus around the need to move away from the use of different payment systems for different types of providers, as this inhibited an alignment of resources and thus hindered integrated working. In particular, the national tariff (still referred to as 'PbR') was an impediment to collaborative working, as it concentrated resources in acute providers. Moving to a common payment system would also help to address system financial challenges. Both commissioners and providers were keen to move towards capitated budgets and we found some evidence of innovative payment systems that aligned incentives were being operationalised.

An integral part of place-based cooperation is the sharing of financial risk between partners. Risk-sharing was more challenging for systems with a larger number of organisations, as well as those with financial challenges. Additional challenges arose from the relative size of an organisation and its capacity to bear risk.

Future development of commissioning

Commissioning would become more strategic, with some functions undertaken jointly with neighbouring CCGs across the STP footprint, and some with the LA. It was expected that providers would embrace more detailed, day to day commissioning functions. There was some uncertainty whether commissioning in its current form would endure, but there would still be a role for planning. Clinical involvement in commissioning was largely seen as beneficial and expected to continue.

Discussion and Conclusions

Integration of services was receiving major attention at local level. No particular organisational form was thought necessary to promote increased collaborative working. Rather, changes are being led by detailed joint work between individuals at local level. Sites adapted their approaches to local circumstances. Personal relationships and taking sufficient time to develop trust through repeated joint working were vital. Integrated working between the local CCG and the LA was a central part of collaborative working. However, important cultural and structural barriers to integrated working between CCGs and LAs need to be addressed. These include different attitudes and cultures.

Collaborative working was also taking place at the larger STP footprint. This included Joint Commissioning Committees of CCGs across an STP footprint. Partners were using STPs for activities that benefitted from economies of scale. A key strategy to coordinate integrated working at local CCG and STP levels was the adoption of the principle of subsidiarity by STPs. Thus, there is a need to recognise that STP development needs to go with the grain of previous partnerships, and to allow local systems to undertake changes at the appropriate level. STPs need to concentrate on changes which require a larger footprint.

Commissioners and providers are investing significant effort into developing an integrated system. This has implications in terms of accountability, provider payment, risk-sharing, data

systems and workforce. Major barriers, such as organisational boundaries and the pricing regime of the internal market need to be overcome. The new direction on pricing expected from NHSI and NHSE will be important in allowing local systems more latitude in how to use incentives.

STP level systems were developing arrangements for mutual accountability. Trust and the sharing of information were vital to the success of such arrangements. STPs will need to continue to develop accountability arrangements, especially those that aspire to become ICSs as there is potential for ICSs to operate under a more autonomous regulatory regime.

Integrated working presents an opportunity for a more balanced allocation of resources across the system. The move to new types of payment systems such as capitated budgets is helpful. While there may be some resistance to reform of current pricing rules, our research shows a willingness on the part of providers to implement innovative payment systems. The new national guidance on pricing will be important in facilitating innovative uses of financial incentives, at local level. A potential new payment approach could blend elements of block contracts and activity-based funding in order to retain the benefits of both.

There is a need for national oversight and assistance to form and develop risk share arrangements and mechanisms. This could take the form of an organisational layer between NHSE and STPs and ICSs. The development of regional collaborations between NHSE and NHSI is therefore welcome.

A number of issues should be addressed to expedite integrated working. While senior managers favour closer integration between organisations, it is clear that the interorganisational level may not be the most salient issue. It is important that staff engaged in the administration and delivery of services have the ability and motivation to implement these plans. Data systems need to be shared across organisations. And finally, the staff need to focus on their respective roles in the local system, rather than their employer organisation.

Irrespective of how the current policies of place based integrated care develop, there will always be a role for planning, and thus a degree of commissioning in the NHS, as a publicly funded system. Strategic decisions need to be made about the allocation of public resources between different services in order to optimise population health and wellbeing. Our results

point to a system in which the strategic planning element of commissioning will be implemented at the local place (CCG) level, in conjunction with the LA, as well as at the STP level. It is important that the detailed specification and monitoring of individual services is also maintained in order to ensure accountability and this may be undertaken by other bodies (possibly lead providers of networks of sub-contractors or alliance contract parties). These fundamental tasks of service planning and monitoring are essential to an effective healthcare system, whether they are labelled 'commissioning' or not.

Glossary

5YFV	Five Year Forward View
ACO	Accountable Care Organisation
AO	Accountable Officer
BCF	Better Care Fund
BMA	British Medical Association
CCGs	Clinical Commissioning Groups
CIP	Cost Improvement Programme
CQUIN	Commissioning for Quality and Innovation
GB	Governing Body
HRA	Health Research Authority
HSCA 2012	Health and Social Care Act 2012
HWB	Health and Wellbeing Board
ICS	Integrated Care System
JCC	Joint Commissioning Committee
LA	Local Authority
LMC	Local Medical Committee
MCP	Multispecialty Community Provider

MoU	Memorandum of Understanding
NCM	New Care Model
NHSE	NHS England
NHSI	NHS Improvement
PbR	Payment by Results
PCT	Primary Care Trust
PSF	Provider Sustainability Fund
QIPP	Quality, Innovation, Productivity and Prevention
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership

1. Introduction

1.1. Policy background

The Health and Social Care Act 2012 (HSCA 2012) introduced major changes into the commissioning system for the English NHS in 2013. The 'new NHS' established by the HSCA aimed to move away from what was characterised as the previous 'top down' approach to system management, 'liberating' the NHS from political control via the establishment of an arm's-length body, NHS England (NHSE), and empowering local clinicians to make decisions on behalf of their patients by forming local Clinical Commissioning Groups (CCGs). CCGs replaced the larger, more uniformly sized and governed Primary Care Trusts (PCTs) (Department of Health, 2010). This new system is operationally more complex. Whereas previously PCTs held responsibility for commissioning virtually all the care required by their local geographical populations, commissioning responsibilities for local populations are now divided between a number of different organisations. In addition to CCGs, NHSE is responsible for, inter alia, 'specialised commissioning' and local authorities now commission public health interventions (as well as the social care for which they were previously responsible) (Health and Social Care Act, 2012). The scope of what constitutes 'specialised services' has also been redefined, requiring commissioners to redefine the boundaries of their work (Weaving, 2012). Finally, it should be noted that there was an increased statutory emphasis on the stimulation of competition between providers by commissioners as a method to improve quality and efficiency of services (Health and Social Care Act, 2012).

In the five years since the HSCA 2012 took effect, there have been several important policy developments which affect the 'new commissioning system'. First, in 2014, *The Five Year Forward View* (5YFV) (NHS England, 2014) did not mention competition on the supply side and instead focussed on how organisations in the NHS need to cooperate with each other, and in fact at times merge to form larger organisations, known as 'new care models' (NCMs). These NCMs include Multispecialty Community Providers (MCPs); Primary and Acute Care Systems; Urgent and Emergency Care Networks; Enhanced Health in Care Homes and Hospital Chains (NHS England, 2014). A nationwide programme of NCMs has been initiated pursuant to the 5YFV, under which the first wave of NCMs are known as 'Vanguards'(NHS England et al., 2015a) .

Secondly, it should also be noted that there are other organisational changes being implemented across the country, including a number of configurations designed to improve the integration of care (known as 'Pioneers') which predate the introduction of the Vanguards (Department of Health, 2013). These organisational and service delivery changes take a range of forms including both horizontal integration, such as closer cooperation between health and social care; and vertical integration, such as closer working between hospitals and community services (Erens et al., 2016).

Thirdly and most importantly for commissioning, in 2015 the relevant NHS national bodies issued a further policy document introducing the concept of local cooperative, place based planning, known as Sustainability and Transformation Plans, and from March 2017 Sustainability and Transformation Partnerships (STPs) (NHS England et al., 2015b, NHS England, 2017). Guidance emphasised that this planning process would involve all '*local leaders coming together as a team, developing a shared vision with the local community, which also involves local government as appropriate; [and] programming a coherent set of activities to make it happen*' (NHS England et al., 2015b). Local areas were required to define their 'transformation footprint', which was needed in order to produce and deliver a local STP for the period October 2016 to March 2021. There are 44 local areas, almost all of which include several CCGs, and many of which include seven or eight. Therefore, it will be necessary for CCGs to work together to provide system leadership in their local economies. In addition, NHSE stipulated that each local economy designate one individual as the leader for this process (NHS England et al., 2016).

Nevertheless, it should be noted that there have been no relevant legislative changes, so the HSCA 2012 provisions concerning the respective roles of NHS commissioning organisations (particularly CCGs) and the regulatory framework in respect of competition remain in force. These provisions indicate that clinically-led CCGs are responsible for commissioning the majority of health services and competitive procurement is to be preferred, although not in all circumstances.

The implications of these many recent developments are that there is now a more complex local landscape of organisations (and configurations of organisations) all of which need to be involved in the planning and commissioning of local services; and that CCGs need to be able to find ways to engage with them effectively. This is a complex task for relatively new

organisations, which have limited managerial resources and rely on leadership from GPs on their boards. It will require CCGs to work in ways other than mainly negotiating and monitoring formal contracts with providers of care. In addition to that continuing key task, they will also need to work collaboratively with stakeholders over whom they have no formal authority including: GPs; independent and voluntary sector organisations; local authorities; other CCGs; NHSE; Vanguards, Pioneers, NHS trusts and NHS Foundation Trusts. It should also be noted that, new commissioning developments (specifically the STP process) include an explicit requirement for patient and public involvement in making commissioning decisions (NHS England et al., 2015a). Issues such as reconfiguring local services (including primary care); implementing Better Care Fund (a pooled fund to encourage integration between CCGs and local authorities) proposals; and possibly decommissioning services and other attempts to improve efficiency and contain overall costs are likely to arise locally.

1.2. Need for research

The implementation at local level of these new policies, including the emphasis on place-based planning requires investigation. Although there are several studies currently underway evaluating integration Pioneers (Erens et al., 2016, Policy Innovation Research Unit); Vanguards (at local level (NHS England et al., 2015a); and at national level (Checkland K. et al.)), there is no in depth research being undertaken into the effect of these changes on CCGs and local commissioning.

The Health Services Journal published a national survey of CCG Chairs and Accountable Officers in 2016 (Health Service Journal, 2016) reporting that local system priorities include the need for CCGs to play a bigger role in instigating and coordinating plans across the local system. It appears that there are early indications that CCGs are struggling to carry out their statutory obligations in the new context.

1.3. Research questions

PRUComm has undertaken a study to investigate how recent developments have affected the process of commissioning and planning at local level.

The research questions are:

1. How are CCG internal processes of decision making changing?
2. What is the role of the individual CCG in the current commissioning landscape?
3. How is accountability maintained by CCGs in the current commissioning landscape?
4. How is competition and the current pricing regime relevant to CCGs' commissioning decisions?
5. How should commissioning develop?

2. Study design and methods

The study consisted of three in-depth case studies to investigate recent developments in commissioning from the perspective of CCGs. The use of case studies was thought to be the most appropriate research design as case study interviews and documentary analysis were informed by the contextual information we were able to gather by concentrating on three specific CCGs across the country. We were able to pursue our research questions in-depth, informed by interviews and examination of local documents (including STP plans, alliance agreements, Memoranda of Understanding, and STP consultation documents).

Ethical approval for the study was granted by the London School of Hygiene and Tropical Medicine internal ethics committee on 13 July 2017. We participated in a streamlined NHS research governance approval process piloted by the Health Research Authority (HRA). Due to the low burden nature of this study and the seniority of the research participants, we were not expected to separately notify this project to the Research and Development office of each NHS organisation from which we sought participation. The seniority of the research participants meant that the research participants were themselves the most appropriate parties to confirm whether they were willing to participate. NHS research governance approval from the HRA took 2 months (applied for on 7 August 2017 and granted by the HRA on 6 October 2017). The fieldwork was undertaken between November 2017 and July 2018.

During the fieldwork we interviewed 22 people (in 21 interviews) from CCGs, NHS providers and local authorities across the three case study sites. VM, PA and IM conducted the interviews. The interviewees comprised Director (19) and managerial (3) level staff. Tables 1 and 2 summarise the interviews conducted by case study site.

Data analysis was conducted using a thematic analysis with the main themes derived from the research questions.

Table 1. Interviews by case study site

Case Study Site	Location of CCG	Number of Interviews	Number of Interviewees
CCG1	Midlands	8	8
CCG2	London	6	6
CCG3	North	7	8

Table 2. Interviews by case study site and type of service and provider

	CCG1	CCG2	CCG3
Commissioners			
CCG	2	3	5
Local Authorities	0	1	1
Providers: NHS			
Integrated Acute and Community	4	1	1
Community and/or Mental Health	2	1	1

3. Case Study Sites

3.1. CCG1

CCG1 was located in the middle of England and crossed the boundaries of two local authorities, covering all of one and part of another. This meant that the CCG comprised two distinct geographical footprints. In both local authority (LA) areas served by the CCG, the health outcomes were relatively poor, with high levels of deprivation, health inequalities and reduced life expectancy compared with the England average. There were significant numbers of minority ethnic groups within this population who experienced higher health needs.

An integrated acute and community Trust covered the whole catchment area of the CCG. This provider delivered acute services for the whole of the CCG catchment area and provided community services to one of the LA footprints. A community Trust provided community services to the other LA footprint. Two mental health Trusts provided the majority of mental health services, one for each LA footprint.

CCG1 was a partner in an MCP Vanguard. The AO of CCG1 became the STP Lead when the STP was established. As the CCG covered part of an LA and this LA was a partner in a neighbouring STP, CCG1 had contracts with a mental health Trust and a community Trust that were partners in the neighbouring STP.

3.2. CCG2

CCG2 was co-terminous with a London Borough. The CCG served a local community that was very ethnically diverse, with approximately two-thirds of the population comprising Black, Asian and minority (BME) ethnic groups. There were high levels of deprivation but this was changing as the population changed due to development and regeneration of the Borough. There were also high levels of health inequalities and disparities in life expectancy within the Borough.

The main provider of acute services was an integrated acute and community Trust that also served CCGs in two neighbouring Boroughs. Mental health services were provided by a community and mental health Trust that served other CCGs in London as well as CCGs outside London. Community services were provided by the integrated acute and community Trust, the community and mental health Trust and a GP Federation working together in partnership.

CCG2 was an Integrated Care Pioneer pilot site and a partner in an MCP Vanguard. The STP Lead was formerly the Accountable Officer of CCG2 and became AO of all the CCGs in the STP.

3.3. CCG3

CCG3 was located in the North of England. The CCG had a small ethnic minority population and ranked poorly for life expectancy compared to other districts across England. A minority

of the population lived in neighbourhoods that were in the top 10% most deprived areas in England.

There was one integrated provider of acute and community services and one provider of mental health services. Both Trusts provided services to other geographical footprints.

The CCG was a partner in an MCP Vanguard. The STP Lead was from a provider Trust.

4. Findings

4.1. CCG internal processes of decision making

We were interested in whether CCG internal processes of decision-making had changed in response to wider changes in the commissioning environment. CCG decision-making processes and structures were evolving in response to changes in the wider commissioning context. There was some evidence that the CCG GB decision-making was becoming more strategic. GPs remained involved in decision-making at the locality level, indicating that GP involvement in decision-making could be maintained at different levels. The importance of GPs' provider role at both locality and CCG levels was highlighted. The day-to-day concerns of CCG management focused on finance, quality, primary care, integrated care, workforce and system recovery as well as quality. To some extent, CCG priorities were formulated at committees below the GB and these priorities were increasingly informed by partnership working.

4.1.1 CCG decision making processes and structures.

CCG decision-making processes and structures were starting to change in response to changes in the wider commissioning environment and this was demonstrated in a number of ways.

In CCG1, while GP involvement in the CCG GB was unchanged, decision-making by the GB was becoming more strategic and less detailed. The GB was also less about collective decision-making but rather about granting permission for officers to act in a certain way in a rapidly changing external environment:

> *"it feels to me that rather than say 'let's make this decision together', what*
> *we kind of said is well … it's kind of tricky to work out what the right decision*

is, can you tell us what premises do you want to make a decision in, and we'll go off and make those decision because we'll need to make it quickly in this environment.

So rather than say do you want to … you know, the decision to work in partnership with X kind of yes, no or maybe, would be … it's like well, you know, it's probably to say, do we need to work in partnership with an external person in that scenario? Can we have permission to go and find the right person and set it up and make it happen, which is much more, you know, permission to do something rather than the detail of it." (CCG1, Commissioner 1: CCG, GP)

This change had arisen partly because of a change in ways of working, for example due to STPs, without a concomitant change in the legislative framework.

Similarly, in CCG2, the extent of GP involvement in CCG decision-making had not changed. Shared posts at the management level between CCGs in the STP level provided an opportunity to reduce the size of the CCG GB, which was quite big.

We asked CCG interviewees about the extent to which the decentralised locality decision-making structures in some CCGs were still being used. This was to explore how larger scale partnerships affected small-scale local decision-making and if decision-making could be maintained at different levels. The locality decision-making structures were still being used in CCG1 and CCG2. CCG3 did not have locality structures. In CCG1, a GP Commissioner believed that the locality structures would evolve with the role of GPs as providers, rather than commissioners coming to the fore. This reflected previous research that highlighted the difficulty of engaging GPs in a commissioning role (McDermott et al., 2016).

CCG2 had a well-established locality structure. Integrated care boards at the locality level were established as part of the Integrated Pioneer programme and these had evolved into locality health and wellbeing boards. The remit of these boards was expanding to include care planning and management of many community, public health and social services. There was also an ambition to have service benchmarking at the locality level but the data needed to underpin this was not yet available. The Vanguard delivered community services through the localities.

4.1.2 Current focus of day to day CCG management concern

We were interested in exploring if the focus of daily CCG management concern had changed with the increase in partnership working. There were some common areas of management concern across our case study CCGs, reflecting issues of relevance to CCGs since CCG formation as well as those that gained significance in light of partnership working. These concerns included finance, quality, primary care, integrated care, workforce and system recovery and resilience. Interviewees identified partnership working as key to addressing the challenges facing the CCG and the wider system.

In CCG1, the main focus of management concern was on the CCG itself as statutory responsibilities had not changed. While CCGs' responsibility and accountability had not changed the *means* by which they were discharged was changing:

> *"So I now rely much more on partnerships and processes and planning than I used to. And I rely much less on procurement and transactions and PBR and performance management, which initially were the things I used to do a lot of. Now I do much less, but I do much more of this."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

The increased partnership working had lessened the need for the CCG to be "*hard commissioners*" (CCG1, Commissioner 1: CCG, GP) engaged in detailed, day to day commissioning, in favour of addressing issues in partnership with providers. There was also a move towards longer-term planning and building resilience in the system in CCG1.

In CCG2, a key concern was to address the workforce crisis by creating new roles and developing the local workforce by partnering with local schools and educational bodies, while there was also a focus on restructuring the primary care team within the CCG.

For CCG3, system recovery was identified as a major focus and needed to be addressed in order to move onto more innovation and transformation. The CCG worked in partnership with providers to tackle the issue. The issues of workforce and system resilience were also pertinent in CCG3.

4.1.3   CCG decision-making about priorities for commissioning

In two of our case study sites, decisions about priorities for commissioning were first formulated at committees below the CCG GB and were then taken to the GB to ratify. The way in which CCGs made decisions was starting to change with more partnership working and the increasing use of data to underpin evidence-based decision-making.

The AO of CCG1 noted that the way in which CCGs made decisions about priorities for commissioning had changed due to increased partnership working, which entailed compromise:

> *"So we're now more mindful, I think. We make more decisions together with other people than we used to. And that influences the detail of the decisions you do make and the processes you use to make them."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

In CCG1, there was a separate committee focused on strategy, which reported to the GB. The focus of this committee had changed from considering innovative business plans to work in different ways to considering innovative plans for QIPP.

In CCG2, the CCG had proposed that the Vanguard Board take responsibility for considering system pressures and opportunities for improving quality, outcomes and value and make recommendations to a new subcommittee of the CCG GB, focused on finance and investment. There was also an emphasis on developing accurate data across the system in order to make decisions about priorities moving forward.

In CCG3, decisions about priorities for commissioning started with the Joint Strategic Needs Assessment in order to ascertain population health needs and the demands these would place on local services. These decisions were then taken to the Health and Wellbeing Board (HWB). The CCG's GB then ensured that these services were commissioned and delivered appropriately. Decisions were also influenced by engaging with patients and the public, particularly in terms of their experience of healthcare and satisfaction with services. CCG3 also worked with professional healthcare staff such as clinicians and nurses to ensure that the services it commissioned were deliverable.

4.2. Role of the individual CCG in the current commissioning landscape

During our fieldwork, it became clear that CCGs were operating in an increasingly complex commissioning landscape. We were interested in exploring how CCGs responded to the changing environment and to what extent CCGs' role had altered. CCGs participated in governance structures at the local 'place' or CCG level with LAs as well as with a wider set of partners. There was an increasing awareness among CCGs that their statutory functions were exercised in the context of wider system working. This meant moving beyond a primary focus on the CCG area towards a consideration of the wider system. CCGs across the STP footprint formed Joint Commissioning Committees (JCCs) in order to align strategies and approaches across the system. There was variability in the development of STP governance structures across the case study sites. CCG Leads took on the additional role of STP Lead in two of our case studies. A lack of statutory status limited the decision-making powers of STP structures. Another problem in the early development of STPs was adequately engaging LAs. There were various incentives for CCGs and partner organisations to participate in STPs including transformation funding, shared control totals and CQUIN payments for providers. Coordination between the different initiatives was primarily achieved through the adoption of the principle of subsidiarity by the STP. The principle of subsidiarity indicated a preference for decision-making at the lowest possible level, with the STP reserved for areas that would benefit from collective decision-making. Moreover, STPs tended to build on partners' existing governance structures and programmes of work.

4.2.1 Governance and committee structures in the CCG area

At the local CCG level, the focus was on integration of health and social care, operationalised through governance structures and joint staff. All three of our case study sites had MCP Vanguards. In CCG2 and CCG3, partnership working under the auspices of the Vanguard was continuing while this was not the case in CCG1. Rather, CCG1 was developing a local Integrated Care System (ICS) with the main integrated acute and community provider. This is discussed in more detail in Section 4.5.

There were commonalities between CCG2 and CCG3 in the governance and committee structures in the CCG footprint. Both CCGs had Vanguard Boards, which were clinically led. In CCG2, the Chair of the Vanguard Board was a GP member of the CCG GB while in CCG3,

the Vanguard Board was chaired by an independent GP who had recently retired from a local practice to minimise a conflict of interest.

Both CCG2 and CCG3 had had developed joint working arrangements with their respective LAs. They formed joint committees, which oversaw pooled funding and undertook joint planning, decision-making and strategy setting in relation to joint approaches to commissioning and decommissioning. At the time of data collection, CCG2 and the LA were in the process of appointing a joint director of commissioning. There was a similar joint commissioning role at Director level between CCG3 and the LA, which meant that a CCG representative participated in management decision-making at the LA.

Integrated working was not without problems, with tensions arising over budgets and staffing. This was illustrated in CCG3 where the LA had a healthcare commissioning team that undertook commissioning of some services for the CCG, for example diabetes and respiratory services. This team originally sat in the PCT and transferred to the LA following the HSCA 2012 when LAs took responsibility for commissioning public health services. However, this had resulted in an unusual situation whereby the CCG held the budget for services commissioned by the LA. The LA had experimented with different organisational formats such as having the healthcare commissioning staff located in the CCG full-time or part-time. However, these staff were also members of the public health team in the LA and were funded by the public health budget, and therefore the LA was mindful of not losing this expertise and budget and so continued to commission CCG services:

> *"So some of my core budget is probably tied up in delivering CCG core responsibility. And in a way is that a responsible use of what should be prevention money? But the trouble is there's no-one else. If I change the post, the CCG would then be short of those staff, and because the staff involved are so kind of competent, and so experienced, and have got such good relationships with the clinicians etc."* (CCG3, Commissioner 2: LA, Director)

While the LA tried to approach the issue from a population or system perspective, there was also an awareness of the difference in relative budgets with the CCG having a larger commissioning budget for health compared to the LA as well as the effect of budget cuts:

> *"I think the challenge has been because of everybody's budget, because of austerity, and everyone's budget being reduced such a lot, that we've had to*

> *make really difficult choices around our budget, but then really any partner cuts has a massive impact on everyone else, and really trying to work together to manage that."* (CCG3, Commissioner 2: LA, Director)

Despite the challenges, there was an aspiration to have a single commissioning team across the CCG and LA.

4.2.2 CCGs' statutory responsibilities and role in wider health economy

We explored how CCGs exercised their statutory responsibilities in conjunction with their role in the wider health economy. There was an increasing awareness among CCGs that they carried out their role in the spending and oversight of public funds in the context of wider system working. This meant moving beyond an organisational focus towards a system approach.

All three CCGs in our case study sites had formed a Joint Commissioning Committee (JCC) with their neighbouring CCGs across the STP footprint, although the extent of the JCC's development varied in each site. Generally the role of the JCC was to align strategies and approaches across the CCGs. Each CCG produced a scheme of delegation in terms of which responsibilities could be delegated to the JCC, for example urgent and emergency care, cancer and NHSE assurance.

A GP commissioner from CCG2 recognised that the CCG retained statutory responsibilities for spending and oversight of public funds but believed that these responsibilities should be used to support the system:

> *"so a bit like that vision of the STP which is accepting that we're not the doers, it's creating the space for the people who actually really get it to be doers"* (CCG2, Commissioner 1: CCG, GP)

A GP commissioner in CCG2 believed that some of the CCG's statutory responsibilities were about defending the CCG as an organisation, but in partnership working, it was necessary to take the interests of the system over the interests of the CCG, while maintaining oversight of public funds.

As outlined in Section 4.1.2, finance and system recovery were key concerns of CCG management. This was particularly the case for CCG3, which became financially challenged during 2017/18. As a result, a capability and capacity review assessed whether the CCG had

the right plans in place to recover and had the capacity to implement these plans, including within the context of the wider system. This resulted in a system-wide governance structure with the integrated acute and community Trust to bring collective resources together and to formulate joint plans to develop programmes of work that would lead to sustainability.

The lack of statutory basis for CCGs' role in the wider health economy, for example in STPs, meant that informal leadership and relationships with partners gained significance. The AO of CCG1 noted that while the commissioner role had previously been enacted on a wider footprint beyond CCG1, it was always on a statutory basis with a formal delegation or partnership agreement. The STP was different in that it was based entirely on informal leadership that had no statutory basis. This meant that the right to talk to people had to be earned and was not a given. Nevertheless, even with statutory authority, the ability to *influence* peers was an important aspect of leadership:

> *"So if you don't carry the confidence and credibility of your peers, you don't last very long, whether you've got statutory authority or not."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

4.2.3   Development of STPs

CCGs were a key partner in STPs and the AOs of CCG1 and CCG2 were also the STP Leads. Challenges to the development of STPs arose from developing adequate governance structures, the limited powers of STP structures, working with organisations in different STPs and difficulty engaging LAs. While organisations did not have a statutory obligation to participate in STPs, there were a number of incentives for partners that encouraged participation.

4.2.3.1   Challenges in the development of STPs

STP governance structures were not prescribed nationally and it was left to the discretion of each STP to establish its own governance structures. We found some commonalities in structures for CCG2 and CCG3. The STPs for both case study sites had a body representing the Leads of all the STP partner organisations and the voluntary and community sector; an executive group responsible for the operational direction and delivery; an assurance or oversight group, a clinical forum, and a group with patient and public representation.

The lack of a standardised governance structure was a potential problem as there was a risk of inefficient or ineffective decision-making:

> *"So, you've got a democratic state in one scenario that just doesn't get stuff done, or you've got an autocratic state which risks doing the wrong thing. It does get stuff done, but risks doing the wrong thing. Without that legal standing to say, "Right, this is going to be your standardised governance structure. This is how you're going to elect your Leads. They will have jurisdiction over decision making. You break down the legal boundaries in terms of other stuff." Until you've done all of that, you'll have this imperfect state where, as I say, you'll either have inertia through a democratic process or potentially the wrong decision making through an autocratic process."*
> (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

The development of STPs was variable across our case study sites. In particular, for CCG1, initial plans and ideas developed slowly and the STP did not progress as quickly as other STPs, partly because good governance and leadership arrangements were not developed.

There was a consensus that the STP strategic decision-making processes had not taken over from the CCGs' strategic decision-making process. This was because the resources still flowed to the CCG and the STP had no statutory basis or budget. As STPs were not statutory bodies, they were unable to make decisions on behalf of their constituent organisations. This meant that the decision-making processes in the STP were subject to formal ratification by each partner organisation. The STP Director in CCG3 felt that as the committees-in-common contained the Leads of partner organisations, this increased the likelihood of plans or strategies developed by these committees being ratified by individual partner organisations:

> *"So committee in common doesn't delegate decisions but it has power to meet and come up with a shared approach which they then take back through individual boards. And given that their Chair and Chief Executive are involved in the committee in common, the ability for that to get decisions through individual board is quite high."* (CCG3, Commissioner 1: CCG, STP Director)

According to the AO of CCG1, the regulators treated STPs as if they had decision-making powers. This in turn could encourage organisations to behave as if STPs were decision-making entities, despite knowing that this was not the case.

> *"So of course it has no decision-making, executive authority at all. None of them do. None of the 44 do. Some of them ... We all kind of behave like we*

might do a bit, and we're certainly treated as though we do by NHS England and NHS Improvement. But, of course, none of the 44 can make a single decision about anything. "(CCG1, Commissioner 1: CCG, AO and STP Lead)

Nevertheless, the lack of a statutory basis for STPs affected people sitting on the various committees and boards as they questioned the legitimacy of decision-making:

"And I think that certainly when I've been sitting around some of the governance structures, that's what people have kept saying. I don't even know why we're here, because this is meaningless. I have no mandate sitting round this table to go away and tell people to do things, because we have no mandate." (CCG3, Commissioner 2: LA, Director)

A commissioner from the LA in CCG2 saw the delegation of decision-making powers to the representatives of partner organisations as key to integrated working and raised the prospect of legislative change:

"it's about where decisions are made, and at the moment, you know, if you want certain decision to be made, there are certain powers that directors and chief execs can execute when you go along to any meeting, and there are others that they can't without reference back to their Governing Body, whatever that is, whether it's a Cabinet, whether it's a Governing Body or whatever, or a board in their own sovereign organisations. And the challenge that I've kind of posed is, in order to work as streamlined as possible, what powers might need to be delegated to them at some stage? Now, that makes people a bit twitchy, but integration will only go so far if it's not cracked. Now, that could be from a national policy change and legislation, and if Jeremy Hunt's now got health and care, he might see, because he'll see the conflict." (CCG2, Commissioner 2: LA, Director)

Another challenge of STPs for CCGs was the maintenance of relationships with organisations in a different STP footprint. For example, CCG1 had ongoing relationships with a community services provider and a mental health provider in a different STP footprint. This arose from the geographical coverage of the CCG, which spanned two local authorities.

CCG1 maintained that the two different geographical areas in the CCG had always been somewhat of a challenge and they had gotten used to it but managing the CCGs' catchment area over two STPs was slightly more difficult. According to a GP commissioner in CCG1 the CCG did not have a formal role in the other STP (STP2) that covered part of its catchment area. However, a provider partner in STP2 asserted that CCG1 did not engage with STP2. Part of

the reason why CCG1 did not engage might have been an unwillingness to sacrifice part of its catchment area to STP2.

Another problem in the early development of STPs was the difficultly of engaging LAs because LAs "*regarded the STP as the government coming in and trying to tell us how to run things*" (CCG2, Commissioner 1: CCG, Director). However, at a local level, LAs were engaged in partnership working and STPs could potentially learn from these initiatives. Nevertheless, the AO of CCG1 believed that the negative experience could have a long-term impact on the relationship with LAs:

> *"There's still a huge resentment, particularly in local government, to the whole STP thing. That damage will take a very, very long time to work through. Local government has a very long memory. So it will be …The STPs will have come and gone before we've got back to a position of trust with local government at scale. So it's hugely damaging."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

4.2.3.2   Incentives to participate in STPs

Interviewees discussed potential incentives for STP participation. These included a CQUIN payment for providers, the routing of transformation funding through STPs and a shared control total.

A CQUIN payment related to the STP provided an incentive for providers to participate in the STP as 0.5% of the contract value was conditional on meeting requirements as part of the STP process.

> *"There are a few levers. So, the CQUIN monies that we receive, commissioning for quality and innovation, there's about a half a percent in that that is linked to as contributing to the STP agenda. So, there's the odd lever there, but there's not an awful lot legally beyond that really that would put us in the shtook if we didn't."* (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

A Director from the integrated acute and community Trust in CCG2 viewed the CQUIN payment as paternalistic and reflective of the difficulty of engaging some providers with STPs:

> *"we are treated a bit like children, in the sense of, we could be sort of being given money for going to meetings – it's slightly ... I've never encountered anything like that.*
>
> *CQUIN is a scheme that's meant to reward quality improvements, so we get CQUINs for things like the number of VTE assessments we've done on our patients, or our ability to spot and intervene to prevent sepsis, proper clinical outcomes, so to have one put, going to STP meetings, it's a bizarre mechanism, but it kind of gives you some insight, I think, into how, nationally, how difficult it's probably been to get certain providers just to engage and take this seriously."* (CCG2, Provider 2: Integrated Acute and Community, Director)

STPs were taking on an increasing role in estate prioritisation and approval of capital business cases, incentivising participation of providers. STPs were also the route to national transformation money.

A number of interviewees mentioned the control total as another lever. A control total for the STP in CCG1 was not agreed and this was in part, probably due to the financial challenges in some organisations:

> *"The system wide control total hasn't been agreed and, again, that's partly, probably, because of the financial challenges in a few organisations who've got basically impossible control totals and as a result, why as a system would you want to sign up to something that frankly is not going to be hit? It's impossible to be hit. You just take a problem on board without a solution and no one wants to do that. So, until control totals are developed for next year or whenever, that are challenging, but achievable, and generally people ... you've got to be able to influence that process, hopefully, to make them that, rather than them just being arbitrarily imposed with some kind of national calculation. Until you can influence it and they become real, then I don't think there will be STP ... unless an STP around the country somewhere is very fortunate and they happen to have control totals that are achievable for whatever reason. You've got to have targets that are challenging, but achievable and a lot of the control totals out there aren't."* (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

In contrast to the system control total, which incentivised collective financial performance, the Sustainability and Transformation Fund (STF) incentivised the individual performance of acute Trusts. The Sustainability and Transformation Fund (STF) was introduced in 2016/17 in order to return Trusts to aggregate financial balance. Only acute providers could access the STF, conditional on agreeing and delivering a financial control total and waiting times targets. Acute providers' provisional allocation was based on their emergency activity (Dunhill, 2016). The

STF was renamed the Provider Sustainability Fund (PSF) in 2018, targeted at the same objectives as the STF (NHS England and NHS Improvement, 2018). In April 2018, NHSI announced that providers that missed their control total in 2017/18 would still be able to access some funds (Dunhill, 2018a).

In CCG2, as the integrated acute and community Trust was in deficit, the STF money they earned by hitting their control total was set against the deficit so "*in financial terms, it's meaningless*" (CCG2, Provider 2: Integrated Acute and Community, Director). Moreover, this provider had missed the A&E target performance so did not receive the part of the STF conditional on this. This had an impact on the wider health economy:

> *"So the bit of it that relates to A&E they haven't got and that was assumed within the control total, so we're in a bit of a mess. We will somehow muddle through but it's quite hard. So [provider] have a long-term financial strategy that relates to the control total but it's hard because the control total gives ... well it makes it everyone's problem. It doesn't mean it's any easier to solve. So we do have quite a challenge to the health economy."* (CCG2, Commissioner 1: CCG, Director)

The integrated acute and community provider in CCG1 also benefitted from the STF during 2017/18. The provider overachieved on their financial control total and earned a bonus payment. As a result, the provider was in negotiation with NHSI about a more pragmatic arrangement in the new financial year, in terms of a moderated control total. The Director of Finance viewed the STF as critical to supporting the Trust's investment programme.

> *"So, I am just looking to play one year off against another, and NHSI, to be fair, are entertaining that, we'll see, maybe this afternoon, whether that concludes positively. So, I think yes, we have benefitted from that and we've played the game of that, the quarterly approach to that. So, we have used those accounting flexibilities and things that are legitimately at my disposal to make sure we optimise that."* (CCG1, Provider 3: Integrated Acute and Community, Director of Finance)

In relation to NHSI changing the guidance for the STF, so that Trusts who did not meet their control total could still avail themselves of funding, the Director of Finance thought that this had "*undermined the credibility of the STF purpose*" (CCG1, Provider 3: Integrated Acute and Community, Director of Finance). Nevertheless, the STF was an important tool for the Director of Finance:

"So, I am very interested in it and I am very interested in it working with a set ... A clear purpose and a clear set of rules and a set of rules that stick and don't change for expediency at the last minute." (CCG1, Provider 3: Integrated Acute and Community, Director of Finance)

The integrated acute and community Trust in CCG3 did not receive much of the STF due to their sub-optimal A&E performance and this meant they could not reduce their deficit. The Trust highlighted the existence of structural issues that good management could not address. The Chief Executive of the integrated acute and community Trust in CCG3 questioned whether STPs would have a role in allocating this STF funding and if so, what criteria would be used as these could contribute to inequality in funding.

4.2.4   Co-ordination between integrated arrangements at CCG and STP levels

CCGs were operating in an increasingly complex environment with various initiatives at different levels including STPs, Vanguards and moving care out of hospitals. We were interested in exploring how these different initiatives were coordinated and to what extent they worked together. We found that coordination was achieved in a number of ways; principally by STPs adopting the principle of subsidiarity and a place-based approach as well as building on existing processes and systems wherever possible. It was clear that different services were delivered at different levels with the STP level reserved for services and programmes that benefitted from larger scale collaboration and economies of scale. CCGs and LAs coordinated approaches to commissioning and service delivery and made efforts to increase mutual understanding of decision-making processes.

All of the STPs had adopted the principle of subsidiarity, with a preference for decision-making at the lowest possible level. This was reflected in the emphasis on place-based care in STP plans. For example, in CCG3, the places or CCG areas had primacy in the STP and were the focus of a model of integrated care services around a population of 30,000 to 50,000. As the STP was based on subsidiarity, the local, place-based (CCG) area was the primary focus and where most work would take place. The CCG benefitted from engagement with the STP by collaborating and sharing of best practice across the STP footprint. The STP had enabled the CCG to address issues such as access to cancer services, workforce shortages or reconfiguration of stroke services across a wider footprint. This was more effective than their attempts to deal with these issues at a local CCG level.

The attitude of the STP Lead in CCG3 was that they could not and did not want to dictate what happened in the different places in the STP.

> *"And what I've always done is to try and keep the energy where the energy is which is in the places or in the institutions. So our STP as I said is based on subsidiarity so I'm not in charge, I'm not trying to take over."* (CCG3, Provider 1: Community and/or Mental Health, Chief Executive and STP Lead)

The AO of CCG3 believed the STP facilitated a culture of collective working to create a better system while recognising the inter-dependencies and the strengths of each of the places (CCGs) working horizontally and as well as vertically in a system approach to commissioning and delivering care.

Another important coordination strategy was to build on existing work programmes and plans where possible and avoid creating new duplicative processes. For example, in CCG1, the STP was originally set up with a number of core work streams to deliver, driven from the centre and in a holistic way across the whole system. Several of the work streams had existed previously and were subsequently included in the STP vision. CCG2 had commenced a clinical transformation and demand management programme of work with two neighbouring CCGs to move activity from the acute provider into the community and this work programme was incorporated into the STP. In CCG3, integrated working had already been underway for a number of years prior to the introduction of the STP and the STP helped to progress this work by providing access to resources, capacity and expertise.

Key to the successful coordination was the understanding that different services would be delivered at different levels such as the local CCG footprint, the acute footprint and the STP footprint. At the level of the CCG, community-based integrated health and social care services were delivered by Vanguards and their successors. The acute footprint consisted of a number of CCGs coming together to commission various acute inpatient or mental health services. The STP level was used to address challenges around workforce, finance and quality of care and to commission specialist services. A significant benefit of collaborative working at the STP level for CCGs would be an increase in negotiating power *vis-à-vis* acute Trusts and the formulation of a common strategy to tackling acute provider deficits. For example, a GP commissioner in CCG2 felt that all of the CCGs in the STP needed to form a single cohesive approach to CCG2's local integrated acute and community provider in order to make it more sustainable. As this

Trust was the main provider of specialist services for the STP footprint, the commissioning of specialist services at the STP level would encourage a common strategy to the financial sustainability of the Trust by all the CCGs. Another issue was the reconfiguration of acute services, which entailed challenging conversations that benefitted from taking place at the STP level:

> *"And to really sort of break the stranglehold that the acute sector has over our resources particularly, that conversation needs to happen at a bigger level. And that's where I think the STP footprint is better. And having people like [STP Lead] who are proper sort of leaders, can challenge sort of that emphasis on the acute, and look at how we can put more resource into community"* (CCG3, Commissioner 2: LA, Director)

A commissioner from the LA in CCG3 felt that there was scope to move funds around the STP footprint to deal with inequality in funding but this was difficult to do because of the power of acute Trusts and the inability of CCGs to take them on:

> *"And they tried to do it with CCGs I think, thinking that GPs would be a match for acute consultants, but it just hasn't worked.*
>
> *So actually I can see how an STP would have a bit of a better chance. So [name of Trust]….They're a monster Trust, they're not … a little CCG and a CCG trying to take them on around their sort of … that isn't going to happen."* (CCG3, Commissioner 2: LA, Director)

At the CCG level, coordination with LAs was achieved by aligning service delivery strategies and increasing mutual understanding of decision-making processes. CCG2 was facilitating coordination between its various work programmes on integration with the LA by adopting a life course approach to service delivery. Under the Vanguard, the CCG was transitioning towards three life course work streams. The HWB also adopted a life course approach with a restructuring and development of three strategies focused on the same three groups. This reflected an agreement for all the initiatives in CCG2 to come together in the same narrative, and was underpinned by work on an outcome framework, also based on a life course approach.

Coordination between CCG2 and the LA was also achieved by increasing efforts between to better understand how decision-making worked in each organisation in order to recognise that processes and timeframes differ:

> *"as commissioner we do commissioning cycle, but on the borough side this is how decisions happen, and this is how you have to get it through Cabinet, and it actually takes ages. You know, so actually understand it, so you're not getting peed off with your borough colleagues because it's taking ages because that's just the way the borough does business."* (CCG2, Commissioner 1: CCG, GP)

Commissioners in CCG2 tried to make the commissioning cycle very transparent to all of the Vanguard partners by sharing their commissioning intentions. In return, the CCG hoped that the provider partners would share their Cost Improvement Programmes (CIPs) and challenges with the CCG in order to facilitate collective planning. While this had not materialised, the CCG felt that *"we've at least just tried to put everything on the table"* (CCG2, Commissioner 1: CCG, GP).

4.3. Vertical and horizontal accountability of CCGs in the current commissioning landscape

It was clear that CCGs accountabilities were more complex in the changing commissioning environment. In respect of horizontal accountability, the increase in integrated working meant that challenges arose in designing joint accountability and governance structures. A developing theme was that of mutual accountability and peer review, meaning that partners would be accountable to each other rather than to a single Lead or external regulator.

As statutory bodies, NHS commissioners and providers did not generally view themselves as accountable to the STP. Partners viewed their primary accountabilities were to the regulators, organisation boards, and general publics. One STP Lead believed that the regulators viewed STP Leads as accountable for the performance of the whole STP. The non-statutory nature of STPs meant that STP Leads could only exercise their authority through peer influence and relationships. While CCGs upward accountability remained to NHSE, this relationship was starting to change due to increasing co-operation between NHSE and NHSI and their willingness to work with STP leadership in exercising their regulatory function. CCGs continued to engage GP members and the public through various events.

4.3.1 Horizontal accountability to other commissioning organisations and local partners

Two themes emerged concerning horizontal accountability, that of holding commissioners and providers working together in integrated arrangements jointly to account and the differing views of accountability between NHS organisations and local authorities.

Joint working arrangements posed challenges in terms of accountability. While the Board of an individual organisation was ultimately accountable, this was not the case for Boards such as STP Boards or Vanguard Boards created under integrated working arrangements as these Boards had no statutory powers; these still lay with the individual organisations. Joint accountability was easier for smaller, self-contained systems where the majority of the organisation's activity was contained within the system. Systems were moving towards mutual accountability arrangements with partners primarily accountable to one another. In cases of sub-optimal performance, peer learning could be used to improve performance.

Interviewees from both the NHS and LAs acknowledged differences in accountability between the two sectors. LAs derived a bottom-up accountability from the electoral process. In contrast, one LA interviewee felt that CCGs were primarily concerned with accountability upwards to the regulator and responding to national directives. Nevertheless, democratic accountability did not preclude the need for evidence-based decision-making. Another difference highlighted was the ability of LAs to raise revenue leading to a reluctance to hand money over to the NHS.

4.3.1.1 Joint accountability

As organisations increasingly worked together, a key challenge that arose related to joint accountability.

While the boards of NHS or other statutory organisations were traditionally the focal point for accountability, it was not always clear what the equivalent was in a system with joint arrangements or how this could be created. Governance structures created under integrated working arrangements had no statutory powers.

> *"So, I think on one level the governance arrangement for those single organisations is good, the question is, to maintain that accountability and still deliver the principles that come from competition, how do you create*

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that single focal point within an STP or a system, let's say, that holds it to account, but has got consequences, because ultimately holding to account is irrelevant if the consequences don't follow for poor performance and good performance?" (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

Joint accountability entailed joint responsibility between commissioners and providers but this was difficult to create, given the statutory duties of each organisation.

"Well, actually, if ultimately these guys [commissioners] need to be held to account, not for the money they spend, but for the money the provider spends, then that's a shared responsibility on the end of that financial journey. Conversely, the provider, perhaps, should also not only be responsible for some basic outcome measures, output measures, it should also be responsible for the commissioner element of the outcome measures for the system, so the prevalence of COPD, diabetes and what have you. It all comes back to that shared responsibility and accountability, but the key question, I suppose, is, how do you create that in an imperfect environment when you've got the legal boundaries in place?" (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

Moreover, commissioners and providers were accountable to different regulators. The separate regulation of CCGs and providers by NHSE and NHSI respectively could lead to tensions as the focus was on the financial performance of individual organisations. A Manager in the integrated acute and community Trust in CCG1 anticipated that as the regulators grew closer, this would encourage different organisations in the system to become closer too.

In CCG3, the STP was attempting to create more of a coherent system response and encourage organisations to have a single plan and work together. The aim was for organisations to become part of the system leadership and oversight function and this would evolve into a peer-to-peer relationship. This would entail a shift from for example, NHSE telling the CCG to do something to peers telling the CCG that they had to do something because it was a collective effort and responsibility. In CCG2, as provider partnerships developed, there were attempts to create a joint accountability in order to address concerns about who was ultimately accountable for care in the new organisational forms such as the Vanguard:

"there is still anxiety, I think, in lots of different places about, okay, so where does the actual buck stop. So, if we just take [Vanguard], if a patient who is under their care, if something happens, who actually really takes the heat from that? Is it the person who chairs the [Vanguard] board? Or do we need

to think about a Chief Exec or an Accountable Officer for the provider arrangements?" (CCG2, Commissioner 1: CCG, AO and STP Lead)

Joint accountability tended to be easier for systems with fewer organisations, however the relative size of the organisation was important, particularly the proportion of its overall activity dedicated to the integrated working arrangements. The AO of CCG2 believed the provider partnerships needed a common chief executive or accountable officer but it was not easy to come to such an arrangement, particularly in larger systems. An analogy was made with a system where there was only one organisation of a certain type e.g. one acute hospital, one community provider, one mental health provider, one or two local authorities. In this smaller system it would be easier to appoint a joint chief executive who would take responsibility for the system. Even in smaller systems at the local CCG level, a key challenge highlighted was in deciding on the mechanism for mutual accountability for the system financial challenge.

Joint accountability was made more difficult and complex in systems with large providers and the activity under the integrated care partnership was only a small part of their business:

> *"the bits of the acute care that is part of the [CCG2] Borough is a pretty small part of whole of [integrated acute and community provider]*
>
> *So, how does that work for [integrated acute and community provider] and how does that work when, you know, there's the chief exec. So, I haven't quite worked that one through yet."* (CCG2, Commissioner 1: CCG, AO and STP Lead).

An additional anxiety was that if the acute hospital was ultimately responsible, a question arose as to how this lent itself to good quality care, given that the majority of care was delivered outside the hospital.

A GP Commissioner from CCG2 expressed an interest in devolving more of the accountability to delivery teams and this was essentially, what the CCG did with the GP networks in terms of delivery around long-term conditions, which had succeeded to some extent.

A promising development was that of mutual accountability, which entailed performance against a set of shared objectives with partners accountable to each other, rather than to a regulator. This encouraged peer learning in cases where one or a small number of organisations achieved sub-optimal performance.

In CCG3, there was a desire to move towards a mutual accountability arrangement around performance. This would entail a system whereby providers were expected to deliver against a set of standards and outcomes and performance was peer reviewed by other partners. The STP Director in CCG3 felt that peer review would drive clinical motivation to improve and improve standards.

> *"rather than accounting for your performance to a regulator, you're accounting for your performance to your peers, and I think that brings two things. Firstly people are more likely to listen to their peers than they are to a regulator because they've walked in their shoes, they understand the ins and outs of it. Second, it means that the peer is often better placed to diagnose the problems and offer solutions because they've done that job, they've walked in those shoes, etc."* (CCG3, Commissioner 1: CCG, STP Director)

The partners were working towards a place where mutual accountability was as much about driving improvement through peer learning as opposed to just managing failure.

The Director of Finance of the Community Trust in CCG1 saw a similar role for the STP in terms of setting standards and peer review of performance. This interviewee felt that the STP was not very helpful in terms of holding providers jointly to account and this was better managed through conversations between executives and clinicians across organisations. The STP would be best placed to set system wide targets and allocate corresponding roles and responsibilities, such as task and finish groups.

While individual partners were still accountable to the regulators, joint working and accountability could help to address system challenges with regulatory intervention viewed as a last resort.

> *"Accountability still sits with statutory bodies, so there's no change there. You've got the 2012 Act and individual bodies are still accountable to NHS England, NHS Improvement. The philosophy behind this is that fragmentation of accountability that currently exists in the system is detrimental to improved care and financial efficiency. So what we're trying to do is you've got this regulatory accountability as a backstop and NHS England can step in, CQC can step in and NHS Improvement can say this isn't working, we need you to do X, Y and Z otherwise there are going to be significant issues.*
>
> *That all stands. I think what we're trying to do is put something between that backstop position. What we're trying to do is create a network of*

organisations that work together, create shared plans, create shared ambitions so that we've got a better chance of getting after some of the challenges that we face because it gets to that point." (CCG3, Commissioner 1: CCG, STP Director)

The STP Programme Manager in CCG3 felt that the goal of achieving ICS status would provide a strong incentive for mutual accountability. In order to gain ICS status and the associated benefits, the system as a whole, and not just individual partners would need to perform well.

4.3.1.2   Local authority

Interviewees from both the NHS and LAs perceived a difference in accountability between the organisations. The democratic nature of LAs meant that accountability was derived bottom-up from the electoral process:

> *"so it's interesting when you start working with local authority colleagues because the fact that they're elected they feel that they have a sort of much more ... they feel that they are more accountable than we are because of that electoral process. But again that's a super blunt instrument isn't it? I struggle with that in a sense that ... so I ... I think just the fact that you're elected doesn't mean that you actually know what to do"* (CCG2, Commissioner 1: CCG, GP)

A Commissioner from the LA in CCG3 also highlighted accountability deriving from the electoral process. This resulted in LAs having more local accountability whereas in the NHS, accountability was upwards. The perception of this interviewee was that the "*top down control*" (CCG3, Commissioner 2: LA, Director) of the NHS meant that CCG colleagues had to implement directives from NHSE that might not necessarily fit with the local context.

> *"Because we're accountable to the population, we're accountable to our elected members. I'm not saying it's perfect and I think [place] is a really good local authority, but it is just brilliant not to be constantly jumping to a sort of national, very disconnected agenda. I really like that about local authority."* (CCG3, Commissioner 2: LA, Director)

It was unclear how the inconsistency between the LA and NHS would be resolved and this potentially posed a dilemma for the centre.

> *"you know, one way or the other, they either devolve accountability of the NHS down to a local level, which I can't yet see them doing, because then the argument would be, well, it's not the National Health Service.....or they*

move Adult Social Care into the NHS, but they couldn't afford it. Because if local authorities are gathering taxation through council tax, and local authorities will draw from their reserves to fund demand, the NHS is not going to be able to do that. So there's something really fundamentally at the centre that needs to be addressed." (CCG2, Commissioner 2: LA, Director)

Nevertheless, democratic accountability did not preclude the need for evidence-based decision-making. A GP Commissioner in CCG2 felt that while the LA derived its accountability from the electoral process, this did not necessarily grant them a free rein to carry out decisions and it was important to make decisions based on data and evidence as much as possible.

> *"And when you have a politician who has a policy that flies entirely counter to all of the evidence I really struggle with that."* (CCG2, Commissioner 1: CCG, GP)

Another difference between the NHS and LAs was the ability of LAs to raise revenue leading to a reluctance to hand money over to the NHS.

> *"You know, you can have the Mayor who can put a layer of protection around the health and care system in the Borough that you can't get from anyone else so, you know, the potential is there. But when you've got, you know, care funded through revenue raising, through council tax precept, the Mayor would never be minded to give all of that over to the NHS. Why should he? And I don't think some of those kinds of connections have been made, or they have and then in that case, they need to make it all revenue raising through a local system. But then they lose control of the centre, so they can't have it both ways."* (CCG2, Commissioner 2: LA, Director)

4.3.2 Accountability of organisations to the STP

On the whole, STP partners did not see themselves as primarily accountable to STPs, but rather to the regulators, organisation Boards and local populations. This was because statutory organisations could not be accountable to a non-statutory entity.

> *But, we don't have an accountability to the STP, yet. I couldn't quite make sense of how the statutory body can be accountable to a non-statutory body, in the sense of what I understand accountability to mean."* (CCG2, Provider 2: Integrated Acute and Community, Director)

There was a consensus between the STP Leads that they had no statutory powers over the other STP partners and could only influence partners and ask for their cooperation:

> *"I call on my provider colleagues to help support me in that [STP activities]. But I can't really tell the Chief Exec of [provider] what to do."* (CCG2, Commissioner 1: CCG, AO and STP Lead)

Nevertheless, one STP Lead felt that NHSE behaved as if partner organisations did have some accountability to the STP:

> *"I don't think there's any ambiguity, other than by the regulator. I don't think any of the partners have any ambiguity about that. I am very clear I'm not the boss of anybody as the STP Lead."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

One provider recognised that there was no direct legal accountability, there was a sense of accountability arising from CCGs sitting on the STP Board.

> *"So, even if you look at it from a parochial point of view of the people that pay you as commissioners sit on that Board and if you act inappropriately, poorly, you fall out with those people and actually, ultimately, they are still the people that hold the contracts. So, it's quite useful that you don't fall out with them. So, from a straight commercial local perspective, there's still a black and white relationship there."* (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

The AO of CCG1 felt that the partners had a moral accountability to one another, represented by the STP. While this was different from a legal accountability, it was just as important.

As statutory organisations remained individually accountable, collaborative arrangements would need to be put in place for joint agreements to be made at the STP level. This underlined the fact that STPs were bottom-up arrangements in the sense that they were comprised of organisations working in partnership and not an external entity that organisations were subservient or accountable to:

> *"I think is a fundamental misunderstanding often of STPs. They are a servant of the organisations that are in the partnership, they're not the master, because they can only get authority that's delegated from the organisations."* (CCG3, Provider 1: Community and/or Mental Health, Chief Executive and STP Lead)

There was a sense that the STP partners feared a loss of power due to upward delegation to the STP, and did not fully appreciate that powers were being delegated down to the STP from NHSE and NHSI, resulting in an increase in collective decision-making power.

> *"That's what we've really battled to overcome at the start. Power is hugely important and the perception of a loss of power is really hard for people."*
> (CCG3, Commissioner 1: CCG, STP Director)

For example, in CCG3, NHSE was keen to work with the STP leadership in exercising its regulatory function. This meant that NHSE wanted to work increasingly through the STP leadership, rather than with individual CCGs. In practice, this meant that the STP Lead and Director were more closely involved in conversations about CCG performance. This would potentially be welcomed by CCGs as the view of the STP Director was that the relationship between NHSE and CCGs tended to be risk averse - if CCGs were performing satisfactorily, then NHSE did not interfere. Nevertheless, if CCGs did not meet regulatory standards, particularly in terms of financial performance, it was felt that the level of scrutiny that NSH E brought to bear on the organisation was heavy-handed.

On the other hand, a Commissioner in CCG2 viewed the STP in terms of an additional layer of control, rather than a substitute for NHSE regulation:

> *"But for me the STP is kind of, yeah so what, that's the plan and we have this control on top of everything else."* (CCG2, Commissioner 1: CCG, Director)

4.3.3   Accountability of STPs

While the regulators treated STP Leads as being accountable for STP performance, STP Leads had no statutory powers that they could exercise in this capacity.

The AO of CCG1 believed that NHSE and NHSI treated the STP Lead as being accountable for the performance of the STP. The AO of CCG1 cited a hypothetical example of a problem with quality performance at an acute provider in the STP footprint. Although the AO was not directly responsible for this issue as CCG1 did not commission the provider, the AO of CCG1 as STP Lead was the person who would be contacted by the regulators and expected to deal with the problem. Therefore, the regulators were positioning the STP as the party accountable for care standards due to the STP's work in this area.

The AO of CCG1 believed that the regulators behaved in this way to induce the same behaviour throughout the system as a means to circumvent the current legislation:

> *"I think what NHS England and NHS Improvement are doing effectively is inducing a behaviour by behaving a certain way themselves.*
>
> *So it's quite an interesting ... I call it Tinkerbell management. If you wish for it enough, it will happen. I think that's what they're doing. So, obviously, what they'd like to do is have a new Health Act that swept away all the Lansley reforms, because they don't work. What they can't ... There's absolutely zero prospect of that happening, particularly now. Not in the short term. So they've just decided to behave as though they had swept it all away and they've got 44 health authorities which they're holding to account for delivering the NHS constitutional standards and financial balance. Truthfully, that's what they're doing."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

The AO of CCG2 felt that the STP Lead was accountable in terms of delivering the STP plan and approving access to transformation funds. Therefore, it was the responsibility of the STP Lead to ensure the STP had a clear vision, sufficient resources and the right approach to carry out its activities. However, the AO of CCG2 noted that the only direct control came from being a commissioner and that, in the absence of statutory changes the role of STP Lead would

> *"always be a challenge and, possibly, not very long-lasting because of the fact that ... you know, in theory, they are here to help transition the system into the accountable care systems where you've got more of the components of some commissioning arrangements within a provider sort of framework."* (CCG2, Commissioner 1: CCG, AO and STP Lead)

STP Leads exercised their role of STP Lead through their influence and relationships with partners. The AO of CCG1 described the fine balancing act the STP Lead had to strike between being able to influence peers in order to meet the expectations of the regulators and maintaining a cordial relationship with partners and not being viewed as exerting authority without any statutory basis:

> *"I'm seen as someone who might exert an influence on that [STP performance], and should be, and if I'm not able to, I think I'd be judged harshly by the regulator. But, of course, I'm mandated by my peers, so I've got be careful how I play that. Until systems are in special measures, there's no right of intervention.*
>
> *So it's a tricky old game really. I think the truth is there's a lot of implied authority and there's a lot of peer pressure that can be exerted."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

STP Leads also participated in various engagement activities to ensure communication and accountability:

> *"I regularly do rounds of meetings, almost as an ambassador for the STP, with different parts of the accountability system. So Health and Wellbeing Boards, Overview and Scrutiny Boards, the public generally. So we all take those things seriously, but we've tried not to put in duplicative processes."*
> (CCG1, Commissioner 1: CCG, AO and STP Lead)

Whatever way power was exercised, there was an expectation that enhanced collaboration would result in system improvement, that had not been possible previously. The success of STPs would be judged by the degree to which system improvement was achieved.

4.3.4   Vertical accountabilities of CCGs

In addition to the new horizontal accountability relationships developing from integrated working, CCGs still had to fulfil vertical accountability obligations to NHSE and their members and local publics.

CCGs had differing views on the extent to which the STP process had changed their relationship with NHSE. While CCG1 maintained that the introduction of STPs had not affected this statutory accountability, data from the other two case studies suggested the relationship with NHSE was starting to change.

Commissioners from CCG1 believed that the introduction of STPs did not change the statutory responsibilities or accountabilities of CCGs:

> *"But we're clearly a statutory organisation in our own right, with our own set of accountabilities and a board and non-exec directors on a statutory basis, and I'm an accountable officer in law to parliament. It's defined in the Act. And there's nothing that trumps that. That's a legal position. And whether we've got one STP, ten, two, six, 2,000, it doesn't make any damn difference to any of that stuff.*
>
> *So I might have an obligation to partners, but my accountability in law is defined under the Health Act and by my signature as an accountable officer. And all of the other accounting officers, whether they are chief execs of councils or Health Authorities are very clear that there is a legal accountability defined in law."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

While the AO of CCG2 acknowledged a primary accountability to NHSE, since becoming STP Lead, there were regular meetings with the local NHSI director as well as the local NHSE director in order to ensure "*that we're all on the same page and we have a common approach*" (CCG2, Commissioner 1: CCG, AO and STP Lead). This was deemed necessary, as there were often disparities between the messages coming from the national and local offices of the regulators. The STP was working towards a framework for performance quality and financial management across the footprint so the joint meetings also helped to facilitate this.

> *"Because there's no point me having a conversation or having a discussion or thinking about what we're going to do from a commissioning perspective if the providers are doing something completely different."* (CCG2, Commissioner 1: CCG, AO and STP Lead)

These joint meetings were moving towards a more formal structure. Similarly, in CCG3, NHSE and NHSI were members of an STP committee comprised of the leaders of the partner organisations and NHSE's regulated power was enacted through this committee.

STPs had not affected CCGs' accountability to GP members and the public and CCGs continued to undertake various activities to engage these stakeholder groups. CCG3 held regular membership events in order to receive a mandate from the membership. The importance of a strong relationship with the Local Medical Committee (LMC) was also recognised as it was not always possible to have the involvement of every practice in every decision. The credibility of the CCGs' clinical leadership and GB were central to engagement of members.

A GP Commissioner in CCG2 did not believe the STP would change the way the CCG was accountable to the public. There was a need to collect data on the public and service user experience in order to improve patient experience. In CCG2, there was an ambition that members of the public could attend meetings where benchmarking data at a locality level would be presented. This would improve the accountability and oversight of the system:

> *"So, you move some sense of oversight, and what's happening, and why is it like this into as close to the grassroots and the public as we can.*
>
> *....as it gives people the space to have those conversations, what's happening, why is this like this, why are we so different from that other locality, how come, you know, they get phone access to their GP and we don't, and what are we going to do about it. You know, so for those conversations, because in my experience those are the conversations that count because people get*

curious about things and then they start talking to each other." (CCG2, Commissioner 1: CCG, GP)

However, this has not yet happened in practice as the necessary data were not yet available.

4.4. CCGs' use of commissioning levers

Section 4.2 highlighted the extent to which CCG were collaborating with other organisations at CCG and STP levels. We were also interested in exploring the extent to which different commissioning levers such as competition, and payment systems facilitated or impeded collaborative working.

We found divergent views on competition between LA and NHS interviewees. LAs were in favour of competition as they faced dynamic local markets. In contrast, CCGs were in favour of moving away from competition, as they did not believe it was useful for facilitating integration and providers needed to collaborate to address system challenges. A common view among NHS commissioners and providers was that competition did not necessarily drive up quality or promote innovation and could lead to fragmentation of services. Nevertheless, some interviewees including providers recognised that competition could incentivise efficiency and a key question was how to retain such incentives in collaborative working. CCGs used competitive dialogue to procure innovative contracts such as alliance and lead provider contracts, which were used to facilitate integrated working. A policy framework for collaboration was absent and needed to be developed.

4.4.1   Attitudes to and use of competition by CCGs

We explored the extent to which CCGs continued to use competition as a commissioning lever. An important finding was the diverging attitudes to competition between CCGs and LAs.

Commissioning was moving away from competition towards co-operation and commissioners recognised the risks of disrupting the provider market if integrated working was underway. LAs in our case study sites actively procured services. The differing attitudes towards competitive procurement reflected a cultural difference in commissioning between CCGs and LAs. This arose in part due to different market structures. In health, there were a small number of large contracts with a limited pool of providers. In contrast, LAs awarded the majority of the Adult Social Care budget to third sector providers. An LA Commissioner from CCG3 felt

that full procurement processes had worked well in general. The idea of awarding a large contract to a single provider or even a small group of providers working collaboratively without a rigorous procurement process was not agreeable to LAs due to their specific rules of conduct.

An LA Commissioner from CCG3 believed that procurement was more challenging for LAs due to greater public scrutiny:

> *"And that's harder for local authorities than CCGs, because local authorities are subject to more public scrutiny around the way they procure, so we have to stick to ... and I also have concerns around conflict of interest as well and how whilst competitive recruitment processes are very resource intensive, and risk somebody sort of like zooming in with a shiny bid, but the risk is if you don't do that is you get like a bloated provider who ... like at the end of the day it's public money, you're buying services for the public and you need to be able to ensure you've got the best services. So I think it's like a real tension, and I don't know what the answer is."* (CCG3, Commissioner 2: LA, Director)

In CCG2, the LA recognised that there would be discussions with the CCG on issues such as finding innovative solutions without procurement including allocating population budgets to groups of providers. While the LA was willing to move in that direction to some extent, they would not have a blanket policy to work in this way.

Another key difference between CCGs and LAs that could potentially hinder more integrated working was the length of the commissioning cycle.

> *"The cycle of CCG commissioning intentions on an annual basis, I think, is a hindrance. I think, you know, if you really want us to be innovative, give us a longer planning timescale. Let's do it for five years. Having been, you know, quite heavily involved in CCG, NHS kind of work over the last couple of years, everything feels very short-term and, you know, people are spending huge amounts of time feeding a beast instead of taking a step back and saying, "And really, where are we going?""* (CCG2, Commissioner 2: LA, Director)

In order for the LA in CCG2 to undertake joint commissioning with CCGs, it would need to be on a longer-term basis. The Director of Finance of a Community Trust in CCG1 also felt that longer contracts could enable investment in services, which in turn would support sustainability. However, it was important that such contracts included clauses to support the efficiency and effectiveness of the services, in the absence of more frequent tendering.

There was a perception on the part of the LA in CCG2 that the speed of the CCG's commissioning process impeded a proper understanding of the implications in terms of finances and patient outcomes.

The views of NHS interviewees about competition contrasted with those of LA interviewees. In the NHS, there was a desire to move away from competition, as it did not always make sense in the context of the current problems facing the NHS. Competition was expensive and time-consuming and would not address pertinent issues such as estates and the workforce crisis.

> *"going back to the competition in its wider sense and competition between the, you know, we've got three acute hospitals, two mental health and community providers, for me it does not make sense when we've got a workforce crisis, we've got estates issues, we've got quality issues and we've got capacity issues, for them to all be working in competition with each other. It makes a lot more sense if we move towards a common approach or one entry level, one entry point into maternity services or one approach to the recruitment of staff and the support to staff, and better opportunities for rotation and all that sort of stuff."* (CCG2, Commissioner 1: CCG, AO and STP Lead)

Both NHS commissioners and providers viewed competition as resource intensive. A Commissioner in CCG2 believed competition was expensive and not a worthwhile use of money as the NHS was not very good at using competition to procure services and often ended up with the same provider. The Chief Executive of the integrated acute and community provider in CCG3 had experience of both winning and losing tenders and felt they consumed a lot of time. This interviewee believed that a cheaper alternative to tendering in cases of under-performance would be to replace the Chief Executive or relevant manager.

Opposing views on the use of competition between the CCGs and LAs could potentially act as a barrier to more integrated working in the future.

CCGs used competition for different purposes, for example to stimulate the market. CCGs tended to use competition "*at the margins of particular things*" (CCG1, Commissioner 1: CCG, AO and STP Lead) for example for community services and urgent care services. Competition was viewed as useful for more specialist services such as IAPT, where there was a range of different providers available, including local voluntary community interest companies, who were "*flexible and good on their feet*" (CCG2, Commissioner 1: CCG, AO and STP Lead). Commissioners used competition to stimulate the market if the necessary range of providers

was not available. This meant it was used sparingly and only "*where it feels right, as opposed to always being the default button*" (CCG2, Commissioner 1: CCG, AO and STP Lead).

It was the view of the Chief Executive of a mental health Trust in CCG3 that the primary focus of competition and tendering was on mental health and community services rather than acute services. S/he took the view that acute hospitals were allowed to operate in a cartel and that conversations about reconfiguration sought to consolidate services. This interviewee viewed competition as more straightforward in acute care compared to community services as fixed prices for acute care implied competition on quality.

Prior to the HSCA 2012, the decision to tender felt like a choice. More recently, interpretation of the legislation formed the basis for decisions to tender:

> *"And ten years ago when I was a PCT chief executive it felt like it was my choice whether we went to market or not and that choice was driven by a decision tree that talked about is the provider failing, is it not meeting quality standards, is it not efficient or good value for money for the public purse? Are there alternative providers, have we tried to manage change? All those things. In the last five years people have just been obsessed with the law, they have to go to market because the law says, not because it's the right thing to do, which takes me back to my second point really about there's an equal duty to collaborate and we need a bit more of understanding in that."*
> (CCG3, Provider 1: Community and/or Mental Health, Chief Executive and STP Lead)

A Commissioner in CCG3 felt that as long as an appropriate market assessment was undertaken and it was possible to justify an NHS provider as the only suitable provider, it was legal not to run a formal tendering process. Moreover, this Commissioner perceived it as a good practice to generate income opportunities for NHS providers with strained finances in order to avoid financial deficits. CCG3 took a pragmatic approach in deciding when to undertake a tendering process: "*If I know one of my NHS providers simply can't provide that service then I need to do a process.*" (CCG3, Commissioner 1: CCG, Director).

CCGs were increasingly using the competitive dialogue process[3] to procure services, which enabled co-design of services with providers.

CCG1 had tendered a contract for end-of-life services, followed by a competitive dialogue between the CCG and integrated acute and community Trust:

> *"soft market engagement influenced the design and that wasn't to give us a competitive advantage, it was to enable innovation and significant step change improvement in the service, which it demonstrably, we're 18 months or so, and it's demonstrably delivering."* (CCG1, Provider 3: Integrated Acute and Community, Director of Finance)

This Trust acted as an integrating or lead provider and commissioned a supply chain largely made up of the voluntary sector. According to the Chief Executive of the integrated acute and community Trust in CCG1 there were certain conditions that supported this lead provider approach including the commissioning of outcomes rather than inputs and contracts of a relatively long duration with mandated supply chain competition. However, these conditions were not always easy to implement, particularly the commissioning of outcomes:

> *"One of the conditions precedent is that insofar as there is a commissioning voice in that dynamic, it needs to commission outcomes not inputs. That is easy to say and actually, genuinely quite hard to do. So, I think it is genuinely hard to do and I also think people who have always done commissioning for inputs then find it very hard to do, if you see what I mean."* (CCG1, Provider 3: Integrated Acute and Community, Chief Executive)

CCG2 had also used competitive dialogue in the procurement of an alliance contract. In contrast, CCG3 did not use a competitive process to form an Alliance agreement as the CCG viewed it as "*an umbrella agreement [and] it doesn't need to fall within any of the public contract regulations or anything*" (CCG3, Commissioner 1: CCG, Director).

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[3] Competitive dialogue is one of the formal procurement procedures defined in the Public Contracts Regulations 2015. It can be used when commissioners are unable to specify the requirements of the service before initiating procurement. Only potential providers who meet certain minimum requirements are invited to tender. Commissioners enter into a dialogue with potential providers as to how the services ought to be provided. Throughout the process, commissioners must ensure that the principles of transparency and equal treatment are adhered to and that a genuine competition between shortlisted providers has taken place.

The AO of CCG2 viewed the use of a competitive dialogue process as beneficial in helping to shape the service design and outcomes. It also narrowed the field in terms of prospective competitive bids:

> *"the community health services contract was very much based on the registered list size, so it was a whole bunch of GPs, and their knowledge and understanding of the local population. So, you put things out to tender, and depending how you write the specification it narrows the field a bit. And then you can get into competition."* (CCG2, Commissioner 1: CCG, AO and STP Lead)

Nevertheless, a Director from the community and mental health Trust described the tender submission as "*hard work*" and a "*very tense and tricky process*" (CCG2, Provider 1: Community and/or Mental Health, Director) while the competitive dialogue process was "*a very intense period of co-design*" (CCG2, Provider 1: Community and/or Mental Health, Director) during which a system model was developed. The provider partners built on existing work in order to demonstrate the additional gain from the integration of services:

> *So you know, we used the fact that as existing providers in the Borough we were able to demonstrate significant added value and benefits through integrating some of the services that we provide via other contracts, into our offer of the CHS. So that was the kind of kernel if you like of our model for our integrated care delivery system in the Borough.* (CCG2, Provider 1: Community and/or Mental Health, Director)

Despite the intensity and hard work, the process was viewed as being worthwhile as it resulted in a novel way of delivering the services through the alliance partnership and encouraged a more efficient and transformational delivery of services:

> *"I mean the procurement process really forced us as providers to be transformational and to deliver against a contract sum that was substantially less than current, than the previous contract value and the cost of services. So whether or not you'd have got that out of a non-competitive process I don't know."* (CCG2, Provider 1: Community and/or Mental Health, Director)

Interestingly, the mental health and community providers in the other two case study sites also recognised the potential use of competition or alternative levers to manage the system. The Chief Executive of the mental health Trust in CCG3 felt that competition should be less of a feature of any future framework in the context of integrated care but competition might still be necessary to promote quality. The Director of Finance of a Community Trust in CCG1 also

recognised the while competition was not necessarily the only way to manage a system, it was important for system leaders to have levers at their disposal and the development of such levers would require input from the centre:

> *"I don't think competition from the perspective of an economist's you need the right sweet spot on a graph, competition is the only way to go about managing the system, but I do think you need the right mechanisms, the right levers as that controller of the system to be able to effectively do it and I think allowing individual systems to create that is perhaps a little naïve….I think it's more complicated than that and it is more central support in terms of how the system should be governed and managed and competitively developed from the perspective of a collaborative kind of tension."* (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

While providers recognised potential benefits of competition, both NHS commissioners and providers cited examples of how competition had led to fragmented care pathways and services, increased costs and poorer quality of care. Rather than using competition to drive up quality, system working would result in better services for patients and savings reinvested in services. Moreover, traditional notions of commissioning did not generate innovation and the integration of services would make traditional modes of commissioning irrelevant.

> *"There is not a lot of precedent in the literature for writing specifications and putting them to tender as way to drive innovation. Typically, it tends to work quite well if you know exactly and precisely what you want. If you are not terribly sure, you need a slightly more emerging conversation.*
>
> *I think what is increasingly dawning on people who work in commissioning, is that it's easier to use competition to drive specific service provisions, than to use competition to drive service integration."* (CCG1, Provider 3: Integrated Acute and Community, Chief Executive)

The AO of CCG1 viewed competition as unfashionable as commissioning moved increasingly towards co-ordination:

> *"So I think you can forget procurement. I think you can forget commissioning in that sense. It's much more, now, about commissioning as the art of brokering agreements, of coordinating a system leadership, of trying to resolve disputes, normally individual."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

While this position might have deviated from the regulatory framework, the AO of CCG1 did not deem it a serious breach, as there was a consensus for everyone to act in this way and the regulators seemingly condoned this behaviour.

> *"The entire system is breaking the law all at once by mutual agreement. And as long as everybody does, it's OK, because who's going to complain?"* (CCG1, Commissioner 1: CCG, AO and STP Lead)

> *"if we were to say nationally, you know, to our regulators that we were going up for competition on something at the moment, there would be a lot more questions asked than there ever were. You know, previously we would have been told we must ... why aren't we using competition? Now we are being told why are we?"* (CCG1, Commissioner 1: CCG, GP)

Competition was not an appropriate approach to address complex arrangements and it was very unlikely that CCG1 would use procurement to mobilise an ACO:

> *"It seems to me that the idea that we would go out through a major procurement, for example, to procure an Accountable Care Organisation for [CCG1], I think there's one chance in a million that we'll actually do that."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

Moreover, according to the AO of CCG1 it would not make economic sense for the private sector to enter the accountable care market due to the current VAT regulations and the low margins compared to the US and other parts of Europe.

The use of competition held risks for commissioners in terms of disrupting the provider market if providers were already working well together in an integrated way. The prospect of a competitive procurement could inject a level of uncertainty that would be detrimental and delay progress in the short-term if not block it altogether. Moreover, most of the progress towards integrated care was made because of existing relationships and if additional people with different relationships were introduced it would make collaboration more difficult.

Interestingly, despite the differing views on competition between LAs and the NHS, a Commissioner from the LA in CCG3 also felt that competition posed a challenge for CCGs to engage in more integrated working.

Nevertheless, for the Director of Finance of an integrated acute and community Trust in CCG1, it was unclear if procurement obligations would pose an obstacle to more integrated working.

> *"the procurement and indeed competition obligations get in the way of ambition for ICS or whatever. I guess there will be a rub in there somewhere. I think clever people can find a way of constructively working through that without getting lost in judicial review processes or whatever it is."* (CCG1, Provider 3: Integrated Acute and Community, Director of Finance)

While commissioners needed to ensure an appropriate balance of competition and co-operation in the local economy, interpretation of the HSCA tended to focus on competition more than co-operation:

> *"But I think the second thing I would say is that the 2012 Act placed an equal duty on providers and regulators to promote collaboration when it's of interest to the public. It has got an equal duty as it does to competition yet I don't hear people talking about that very much, very often or very loudly whereas I do hear people worrying a lot about competition."* (CCG3, Provider 1: Community and/or Mental Health, Chief Executive and STP Lead)

While there was a clear policy framework in the 2000s around competition, PbR and Foundation Trusts, there was no analogous framework currently for collaboration and this was a problem.

> *"So I think a clearer policy framework within which we operate and a clear statement of what the policy was beyond getting on with it and collaborating."* (CCG3, Provider 1: Community and/or Mental Health, Chief Executive and STP Lead)

The Chief Executive of the mental health Trust in CCG3 viewed collaboration as more difficult than competition as people had to do things outside their own interest, for a higher purpose. While working together was good in theory, in practice it could be challenging, particularly when there were difficult decisions to make, for example in allocating transformation funding. Moreover, working collaboratively required a different mind-set and set of skills and attributes for managers who had succeeded in a competitive environment.

> *"The other point that is really big in this is that every leader in our system has got to where they got to by being very successful within a hierarchical organisational, competitive environment, and the skills and the attributes that you need to be a system leader in that environment compared to one in this environment is quite different."* (CCG3, Commissioner 1: CCG, STP Director)

Therefore, the STP in CCG3 was investing time in developing leaders for these new ways of working.

4.4.2   Views on current pricing structures

There was a consensus among interviewees that the national tariff, still known as Payment by Results (PbR) was no longer fit for purpose and was not conducive to collaborative working. While PbR had been helpful in the past, particularly in managing elective waiting lists, it was no longer useful or affordable. PbR was designed for a health system in which health expenditure was growing and there was a need to increase activity and reduce waiting times. However, the context had completely changed with very constrained resources. Therefore, PbR had led to strained relationships and arguments about activity between CCGs and providers, which did not facilitate collaboration, and encouraged hospitals to increase activity in order to increase income. While PbR was helpful for elective pathways and driving growth in elective activity, it was necessary to increase growth in integrated care pathways and the delivery of services by a range of different providers, which PbR did not incentivise.

Both commissioners and providers acknowledged some of the benefits of the national tariff in terms of understanding costs and value of activity and suggested it could be kept as an internal costing or benchmarking mechanism for providers.

> *"it is keeping the good bits of what behaviour and learning PbR does whilst making sure it doesn't become a constraint in the future."* (CCG1, Provider 3: Integrated Acute and Community, Director)

A Director in the integrated acute and community Trust in CCG1 believed that PbR had served a useful purpose in terms of understanding the link between quality and productivity and money. It would be useful to retain that understanding but not let PbR be a constraint to more integrated working.

The Director of Finance of the integrated acute and community Trust in CCG1 also felt PbR had benefits in terms of providing an insight into provider's costs and encouraging the coding of clinical activity. Similarly, the AO of CCG1 viewed tariffs as helpful for understanding the cost and the value of activity.

"So I think tariff is great. We throw it away at our peril really. Even when we've got alliance contracting, I think you still need to understand tariff, because it gives you a sense of what things are worth, as well as what they cost. So I'm a big fan of tariff actually and I would hate to see it disappear.

I'm not a huge fan of PBR anymore, because I think the transactions of that have become a bit expensive and most systems now can't afford for PBR to work. So either the providers can't live with a PBR income or the commissioners can't afford to pay them, or both. So just running a market without levels of growth in it, at the levels we had when PBR first came in, is proving, for most systems, to be difficult." (CCG1, Commissioner 1: CCG, AO and STP Lead)

However, the Director of Finance of the integrated acute and community Trust in CCG1 felt that national prices did not reflect true costs, leading to loss-making services and the need for cross-subsidisation. Moreover, PbR could constrain innovation and needed to be reformed to allow more innovative service design going forwards.

A GP Commissioner in CCG2 was more overtly critical of PbR:

"It's disastrous, you know, so it's ... it was designed to incentivise increased hospital throughput. Again, absolutely no concept around any value, in fact no result frankly. Again, it's a fantastic example…of bean counting gone crazy really, and so I think it's disastrous. And it's difficult to see how you retrieve it, and that's the ... I think that's the problem." (CCG2, Commissioner 1: CCG, GP)

Providers of community, mental health and primary care objected to PbR as it encouraged resources to flow to acute Trusts. While mental health providers had had to absorb increased demand, the introduction of PbR to mental health was not a panacea, as CCGs had fixed budgets. Collaborative working seen as a more feasible solution to financial constraints.

A Director from the community and mental health Trust in CCG2 criticised PbR for incentivising acute activity and misaligning resources:

"So of course there is a problem with PBR because it incentivises the wrong things. It incentivises the acute Trusts who produce widgets essentially, doesn't it. That's tricky for us as a mental health community provider on a block contract because we have to soak up our demand growth which has been significant over the last five years and our contract money hasn't grown anything like the acute Trusts contract money or anything like the demand growth should warrant. So our argument is that we've been very efficient in

improving productivity to help us bridge the demand gap." (CCG2, Provider 1: Community and/or Mental Health, Director)

PbR impeded a value-based system approach centred on community care for people with complex co-morbidities and the rich population dataset that the Vanguard in CCG2 had built had shone a light on this:

> *"the thing is that the PBR doesn't incentivise us as a system to keep people as well as possible at home when they have complex co-morbidities and you know, we've got some good examples from some of our work around the dataset of, for example, people with dementia attending five or more outpatient appointments at [hospital] when it's very difficult to understand when you're looking at that in aggregate where the value is for the person. When actually, you know, can we do things differently to give them a better experience and hopefully at the same time, produce better value for the system."* (CCG2, Provider 1: Community and/or Mental Health, Director)

This had been partly addressed under the CHS contract in which a rapid access frailty assessment service had been developed, bringing together consultant geriatricians with consultant psychiatrists and therapists to provide a single assessment in place of multiple outpatient appointments. The service was partly funded by PbR for the geriatricians and partly by block contract for the services provided by the community and mental health Trust.

There was a recognition by the Chief Executive of a mental health Trust in CCG1 that PbR reinforced the purchaser/provider split and skewed resources towards the acute sector. The introduction of PbR to mental health would only reinforce competitive behaviour and this was not feasible in the current financial climate. Like the community and mental health Trust in CCG2, the mental health Trust in CCG1 had to absorb increasing levels of demand by becoming more efficient. However, extending PbR to mental health would not necessarily help as it would potentially bankrupt CCGs as providers would be competing for a limited pot of money. The Chief Executive of the mental health Trust in CCG1 viewed the STP as providing an opportunity to use a different approach:

> *"What the STP provides is an opportunity to say, 'look, we recognise that demand is outstripping supply, how do we manage it in a way that isn't just pouring money into acute Trusts?' You manage it by saying to an acute Trust, 'how much do you actually need to run the service? And even if you're doing more operations, we can't give it to you'."* (CCG1, Provider 1: Community and/or Mental Health, Chief Executive)

The integrated acute and community Trust in CCG2 showed resistance to moving away from PbR because of their reliance on payment tied to levels of activity and the financial risk they would face. While CCG2 still used PbR, it was starting to become a problem

> "of course we can't afford it. But the trouble is they've been so bad at counting for years, that it's not been a problem, but it's now beginning to become a problem"(CCG2, Commissioner 1: CCG, Director)

A Director from the integrated acute and community Trust in CCG2 argued that the lack of consensus between the CCG and Trust on activity levels would make it difficult to agree a block contract, but this was not a major issue under PbR as the Trust maintained they were paid for the activity undertaken. This interviewee recognised that it would be easier to implement payment reform if there was agreement on optimal levels of activity, as then there was only a need to manage the risk presented by the activity not achieving its objectives. The move to a block contract under current activity levels would shift most of the financial risk to the integrated acute and community Trust. A Director in the Trust felt there was a perception that Acute Trusts wanted activity to increase but this was certainly not the case for non-elective activity as there was insufficient capacity to address growing demand and this could create a clinical risk. It was felt that changing the payment system should not be the main priority as it placed more financial risk on the provider in addition to the increased clinical risk. Therefore, the Trust was in favour of redesigning clinical services in order to contain activity and then reforming the payment system to support and incentivise this clinical redesign.

> "But, it's starting with the payment system, that's always ... It paints the payment system as the problem, and fixing the payment system as the solution – I don't think either of those things are true." (CCG2, Provider 2: Integrated Acute and Community, Director)

A Director from the integrated acute and community Trust in CCG2 maintained that focusing primarily on payment reform created a suspicion that CCGs wanted to reduce their financial risk in the context of limited funding growth and increasing demand for acute care. Furthermore, many of the levers for controlling demand were outside the control of Acute Trusts. The integrated acute and community Trust was interested in more partnership working as it allowed them to share their views on how primary care could work differently to manage demand better. Another problem faced by this Trust was very long elective waits and a large backlog of activity. This meant that any reduction in activity would be difficult to sustain in

the short-term due to the disparity between demand and capacity. It would be necessary for a block contract to take the pent-up demand into account, which would be challenging.

> *"So, until we're at balance in terms of referrals and our capacity to treat referrals, there's a risk of going to a block, for both sides, because I think you just, from a commissioning perspective, you don't ... you can't easily identify which elements of the service you're commissioning are actually reducing demand, relative to the previous level of demand, and which are reducing waits compared to the previous level of waits."* (CCG2, Provider 2: Integrated Acute and Community, Director)

In contrast, in CCG1, while the integrated acute and community Trust was willing to move away from PbR towards a payment system with shared incentives, the Director of Finance of the Trust believed that there was some resistance to this in the CCG. The contractual relationship between the CCG and the Trust was largely characterised by a tariff-based contract with a mixture of national and local tariffs. The Trust viewed the CCG as being "*diligent in scrutinising the data and being challenging as regards counting, coding and all of those matters*" (CCG1, Provider 3: Integrated Acute and Community, Director of Finance). In moving towards more integrated working, this approach was causing tension, both within the CCG and between the CCG and the Trust. The approach to contracting maintained by the CCG's finance team contrasted with the ambition of the CCG's AO to move toward a different way of working.

> *"So, while certainly we will hear from the Accountable Officer, a forward-looking exposition of how things could be, how things could be different, the translation of that into how we might do business with the CCG and the ability of the finance team within the CCG to get on board with that and be practice in exploring alternative arrangements, I think is quite difficult."* (CCG1, Provider 3: Integrated Acute and Community, Director of Finance)

The integrated acute and community Trust had shifted the debate in the local ICS to recognise that there was a single pot of resources. The opinion of the Director of Finance of the Trust was that both the CCG and Trust had to 'own' the totality of the available funds.

> *"We are one system with one bag of resource, with one common purpose and it is a collaborative effort to square the triangle or whatever you want to call it."* (CCG1, Provider 3: Integrated Acute and Community, Director of Finance)

The Director of Finance of the Trust felt that while the CCG understood this at an intellectual level to varying degrees, they were struggling to put this theory into action in terms of how they did their work. However, the Trust recognised that learning to work to a new framework and set of rules was challenging, as the system was set up for organisations to succeed in their own right. Moreover, if an organisation failed, the head of the organisation was at risk and this could impede continuity of working and relationships.

> *"So, there is very much you have got to stay alive to be able to deliver the long-term change, and money is one of those things as is quality and safety and whatnot."* (CCG1, Provider 3: Integrated Acute and Community, Director)

Commissioners and providers expressed a desire to move away from using different payment types for different providers towards more common payment approaches such as capitated budgets as funding was based on a defined population and it supported place-based care.

Increased partnership working presented an opportunity for a more balanced allocation of resources across the system. Nevertheless, barriers remained including diverse payment systems, acute Trust debt and limited integration of data systems.

The use of different payment approaches for different providers such as block contracts for community and mental health services and PbR for acute care made it difficult to align resources.

> *"So I suppose the direction of travel is to move towards more of a capitated approach. Because there's a lot of animosity almost between the different providers about how the money flows. And actually, rather than having all those arguments, if we could move towards a capitated approach then that would help"* (CCG2, Commissioner 1: CCG, AO and STP Lead)

In CCG2, a particular challenge was the deficit of the integrated acute and community Trust and according to a Director from the community and mental health Trust, this was impeding a move towards a system with a strategic commissioner having a capitated budget under an alliance contract.

There had been a recent consultation on provider payment in the STP of CCG2. The consultation document outlined the benefits and drawbacks of the payment approaches used in

STP (PbR for acute, block contracts for mental health and community services, and capitation and QoF for primary care) and considered alternative payment mechanisms to support system working including capitated budgets, outcome or incentive based payments, and risk and gain share.

A GP Commissioner in CCG2 recognised that maximising value for a given population and removing historical boundaries in resource allocation was challenging and there was a need for more accurate, detailed real-time data to achieve this.

> *"And until you actually start understanding, not spend, but cost, and actually understanding the pathway, and so some of that … and I think that's where the QI methodology learning has come in, you know, there's something about you really need to understand where the resource has gone and what did you get for it"* (CCG2, Commissioner 1: CCG, GP)

Data integration would support a capitated model. CCG2 had an integrated data system between GP and acute care but community care was not fully integrated in this system. The LA had also been slow to link up its data. While a pure capitated budget might not be achievable in CCG2, the GP Commissioner was confident that something close to this would be possible; "*certainly a different way of moving money around*" (CCG2, Commissioner 1: CCG, GP).

The integrated acute and community Trust in CCG1 were willing to work in an integrated system whereby the CCG gave the Trust a whole population budget and a set of outcomes to deliver:

> *"We think we'd quite happily integrate a system that was based on partnership working with other healthcare providers that took the whole budget off the CCG and just said, "Right, we'll deliver it. Leave us alone. You can ask us for some outcomes."* (CCG1, Provider 3: Integrated Acute and Community, Manager)

The AO of CCG1 maintained that many systems have suspended or modified some or all of the PBR rules. This was the case in CCG3 where the CCG and integrated acute and community Trust had moved to a block contract focused on costs rather than activity. The contract had incentives to make cost savings arising from the equal division of the savings between the CCG and Trust. This Aligned Incentive contract helped to facilitate conversations around how best to organise services to keep within the cost envelope.

> *"Essentially, it's a book based contract rather than a widget based contract which allows you to move away from we're going to fight to an activity and have big rows over coding and counting, to actually, this is the money that the system's got for these services, how do we work together to have the best outcomes for that pot of money."* (CCG3, Commissioner 1: CCG, STP Director)

The contract would incentivise a shift in provider behaviour from seeking to increase activity for profit to increasing efficiency without adversely affecting service quality or patient outcomes. This could entail working more closely with other providers to manage demand. The Aligned Incentive contract created a shared incentive for the CCG and Trust to work together rather than focusing on separate unaligned objectives such as QIPP and CIPs.

> *"what we ended up with through PbR and tariff is a ridiculous situation where the Trust's financial plan and the CCG's financial plan were completely mutually independent. So if the CCG's financial plan was delivered, the Trust was bust, and if the Trust's financial plan was delivered, the CCG was bust, and that's within a geographical footprint like [CCG3]. It's ridiculous. The idea is it's much easier to come up with a system plan and clearly that takes time. It's not like we've got alignments in the contract, everything's going to be fine now. It doesn't save money, it just creates a conversation that allows you to more easily save money, I think."* (CCG3, Commissioner 1: CCG, STP Director)

The contract helped CCG3 to address the problem of financial sustainability (see Section 4.2.2) as it meant moving from PbR to a block contract *"where we've got one pot of money and this is what we can afford to pay for and these the standards of care we want to achieve for it."* (CCG3, Commissioner 1: CCG, AO). The Aligned Incentive contract enabled the CCG and Trust to move away from counting and coding issues to a focus on transformational change.

4.4.3   Use of alliance contracts to facilitate integration

We asked interviewees if they were using alliance contracts to facilitate integration. CCG2 and CCG3 had alliance contracts in operation covering community services. CCG1 had started to explore the use of an alliance contract to support integrated working. The number and range of partners in the alliance contract varied between CCG2 and CCG3. While in CCG2, the alliance only covered NHS providers of community and mental health services as well as general practice, in CCG3, the CCG, the LA and voluntary sector providers were also Alliance partners. In CCG3, the alliance agreement underpinned integrated working in the MCP Vanguard.

In CCG1, the Director of Finance at the community Trust felt that any potential alliance contract would need to include all partners including the CCG as well as providers.

In both CCG2 and CCG3, the negotiation of the alliance agreement was difficult and time-consuming, despite a history of organisations working together.

In CCG2, the challenges were multifaceted. The providers had bid for the contract with the intention that the GP Federation would be the lead provider. However, this did not withstand due diligence as the GP Federation was newly formed with little resources and would not be able to bear the risk associated with the lead provider role. Therefore, part way through the contract negotiations, the contract changed to a "*much more cumbersome alliance model*" (CCG2, Commissioner 1: CCG, GP). There was also a desire on the part of CCG2 to make sizeable savings and this created a tension with the ambition of the providers to improve services. The CCG set a strict financial envelope for the alliance contract value, which resulted in the closing of two hospital wards without any significant impact on acute activity due to a shift of care to the community:

> *"So, the CCG played pretty hard ball with the contract value, so I know that the alliance team thought they needed probably another couple of million, and in fact the deal that they had to be paid some transitional money, so in fact the CCG did not budge on the contract value, but they paid us … and that's … in order to make it work the alliance team had to close those beds. And so, I think by being tough about we'll give you some transitional money but you do have to make it … the books balance by the end of I think it's two years means that they had … they owned the incentive to make it work if you see what I mean."* (CCG2, Commissioner 1: CCG, GP)

Other difficulties in the negotiation of the alliance agreement in CCG2 related to issues around estates and HR.

In CCG3, the main negotiating challenge lay with getting buy-in from the LMC and British Medical Association (BMA).

Much emphasis has been placed on the need to manage demand for inpatient care and to provide more care in community settings. As a result, integrated working could involve shifts in activity between organisations. We explored attitudes to the transfer of services (and thus money) between organisations engaged in partnership working.

The Chief Executive of a mental health Trust in CCG1 believed that an essential element of partnership working was a willingness to give up control and recognise that some services may be delivered better by another partner or in a different configuration. There was a need to focus on the best way of running services, rather than on what each organisation did.

> *"You've still got to deliver the change of behaviour, but if you talk differently, if you talk a different language, if you talk about sharing, if you talk about what you'll give up, if you talk about partnership, if you talk about, actually, it doesn't matter who provides it, what's the best we can do for that service? My personal belief is, that does start then to change your behaviour and you start thinking in different ways, you starting thinking, 'well, actually, rather than just do that on my own, I'll share it'."* (CCG1, Provider 1: Community and/or Mental Health, Chief Executive)

For example, in CCG3 there were plans for community matrons to deliver a late visiting model and primary care would lose financially from this. The CCG was of the view that primary care needed to recognise that the community matrons could deliver the service better and therefore be willing to give it up. Moreover, this would free up GPs' time to spend more effectively in the practice. According to a Commissioner in CCG3, an absence of trust between partners encouraged competition for services.

In practice, the willingness of organisations to cede control of services differed across case study sites.

In CCG2, the integrated acute and community provider was willing to reduce activity and consequently income. The volume of community services provided by the integrated acute and community services provider was approximately halved under the alliance contract. Prior to the contract, this Trust was the provider of all community services in CCG2 but there was a desire to redesign those services through the alliance partnership. The decision to reduce the volume of community services provided was not a difficult one for the Trust. The Trust did not provide community services in the other Boroughs and it was not a strategic decision on the part of the Trust to run community services in the Borough. Rather, this resulted from PCTs divesting their provider arms. The Trust welcomed the opportunity to work with the community and mental health provider and the GP Federation in order to improve service provision.

In contrast, in CCG1, there appeared to be some rivalry between the acute and integrated Trust and the community Trust over the provision of community services. The integrated acute and

community Trust had recently partnered with a GP federation to provide outpatient services and this increased capacity increased their competitive advantage against the community Trust:

> *"It's meant that the Community Healthcare Trust have come to us in different mind-set, because they know that, as a team, us and the GPs could choose to just expand our community service into [place] potentially if that's what commissioners allowed us to do."* (CCG1, Provider 3: Integrated Acute and Community, Manager)

The Director of Finance in the community Trust believed that this attitude did not align with the ethos of alliance working.

> *"It's quite a long way away from perhaps the principles that you would apply to an alliance contract, building trust, relationships and we're all in it together. The answer is, as long as you give us £10 million worth of community work."* (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

Another challenge was the need for partners to adopt the attitude of a single organisation in terms of service delivery on an ongoing basis.

> *"We don't just say that this is an issue in an acute sector or this is an issue in primary care, we say this is an issue as a system. As a system, how are we going to resolve this issue and work as one, as though we're one organisation? That's something that's quite new to us in terms of working as one organisation. We're not one organisation but we like to think that we're working towards that, and that's how we like to think."* (CCG3, Commissioner 1: CCG, Manager)

For example, in CCG3, the Chief Executive of the integrated acute and community Trust felt that while initially there was a common understanding among partners in the alliance about objectives and how to move forward, differences had emerged and partnership working was becoming more challenging. The partners had to behave as if they were one organisation but this was a difficult concept for some partners to grasp.

At the time of data collection, both CCGs were considering plans for the future of the alliance agreements.

CCG2 was in negotiations to expand the alliance to include additional services provided by the mental health and community Trust and the GP Federation. There were also plans for the LA

to join the alliance. The ambition of CCG2 was that the alliance contract would encompass the Vanguard and act as the means to achieve integrated care moving forward.

CCG3 had considered an Accountable Care Organisation (ACO) but put this on hold due to a delay in the national process because of the public consultation and legal challenges. There were also plans for two additional alliance agreements to cover mental health services and end-of-life care respectively.

4.4.4 Attitudes to and use of risk-sharing

An integral part of place based cooperation is the sharing of financial risk between partners. The move towards innovative payment systems and contracts, as described in Sections 4.4.2 and 4.4.3 involves a move away from unilateral responsibility for financial risk towards a system of mutual responsibility.

In general, there were positive attitudes towards risk-sharing in our case study CCGs. It was felt that formal risk-sharing agreements specified in contracts could help longer-term planning and remove the constraints that stopped partners working in the most effective way.

In CCG2, the partners in the alliance contract all shared risk on the outcomes based element of the contract meaning that if one partner did not deliver their responsibilities, the other partners would not receive their money. The alliance contract was inherently risky as once partners started to understand the cost base, they needed to work out how the risk was shared as:

> *"these services cost significantly more than the commissioners were proposing to spend via their published contract money, so there's quite a lot of work done in working out, well who's going to take the risk on that when the contract is actually landed."* (CCG2, Provider 1: Community and/or Mental Health, Director)

Prior to the alliance contract in CCG2, there was a local incentive scheme across organisations involved in delivering integrated care that blended funding from CQUIN and the BCF. The CQUIN funding was at risk, while the BCF money was a benefit. Providers achieved the payment if they delivered against ten outcome goals specified by the CCG.

> *"But it was a very ingenious I think, approach, because that blend of carrot and stick really worked well in getting us off our arses as providers and really*

focusing on those outcomes and taking responsibility with delivering them."
(CCG2, Provider 1: Community and/or Mental Health, Director)

The scheme enabled the partners to test their positions around mutual responsibility for financial risk.

Interviewees recognised that risk-sharing between organisations was challenging for a number of reasons. These challenges related to the size of the system and the number of partner organisations; the system financial challenge; the relative size of organisations; and individual interests of organisations.

Risk-sharing appeared to pose less difficulty in systems that had rationalised the number of organisations as organisational boundaries internalised the allocation of resources. Moreover, a larger number of partners increased the risks of rivalries and divisions. A system with fewer partners enabled a sharper focus on working together. While it could potentially be feasible to streamline the number of NHS organisations to create one commissioner, one acute and/or community provider and one mental health Trust in an STP footprint, it would be more difficult to reduce the number of non-NHS organisations such as LAs.

> *"Systems where there are still genuinely multiple partners, I think that's a harder sell, because the organisations' governance are all set up explicitly to prevent risk share. The boards of directors are charged with not breaching their statutory duties, even if it's for the greater good. And councils are legally unable to. It's illegal for them to spend money from [place] in [place]. You can't. The council doesn't have that legal authority. It would be ultra vires."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

The Director of Finance of the Community Trust in CCG1 believed that it was necessary to have national oversight and assistance to form and develop intelligent risk share arrangements and mechanisms. It was also necessary to be clear about the full extent of the health and financial challenge that the system faced. Interviewees in CCG1 and CCG2 spoke about the need for national recognition and ownership of the financial challenge in the case that this was too large for the local health economy to manage. Both of these case study sites contained acute Trusts with a large PFI debt.

> *"So, there needs to be something done at a regional and national level that says, "Okay, we might not like the answer, but what is the gap and what is the art of the possible in all of this?" as opposed to saying, "What is the gap?*

> *No, you can't tell me you can't close it. Tell me how to close the gap," and repeatedly on record saying, "Close the gap, close the gap," because that's just completely demoralising. So, what is the gap and is it closable and if it isn't, we need a conversation regionally and nationally about what else we need to do."* (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

While the financial challenge had incentivised integrated working as well as increased efficiency and innovation to some degree, for example in terms of management of estates and streamlining services, it had also impeded service redesign

In the STP of CCG3, because of the STP process and collaborative working, organisations were more willing to share information about their financial positions with other STP partners.

> *"So that's one of the most pleasing things about the whole of this STP I think. We've gone from a position where people would never share their financial position to one where last year CCGs drew down differential amounts of money to help each other out which was good to this year we've got, for this year's planning, we know what position the acute hospitals and other providers are in, we know what the CCG positions are, we've reconciled those two. We know the efficiency requirements for every organisation and we also critically know the degree of risk that people are currently carrying to achieve their control total which allows you to see that some people are carrying a great deal but say that they can achieve their financial targets but carry a great deal more risk than some people who are saying they can't. Now I don't think we've ever had that before but that's a degree of trust that exists in the system."* (CCG3, Provider 1: Community and/or Mental Health, Chief Executive and STP Lead)

Nevertheless, there were concerns about differential levels of risk on a larger geographical footprint. Two providers in the STP were in significant financial distress and there was a reluctance on the part of another provider to take on that risk, as they wanted to keep financial resources for their own area.

Another key challenge arose from the size of organisations and the amount of exposure they would face. For example, the alliance contract in CCG2 comprised all of the business of the GP Federation, but was only a small part of the Acute Trust's overall activity. A Manager in the integrated acute and community Trust in CCG1 also recognised this differential:

> *"If you look at our budget in comparison to a GP's budget, it's completely different. So actually, if you were doing it based on income, we'd roll over*

them, but that's not our style." (CCG1, Provider 3: Integrated Acute and Community, Manager)

As a large organisation, the integrated acute and community Trust was comfortable with taking risk and recognised that it needed to take more risk as it was working in a complex and financially constrained environment. However, it needed to be a considered risk and preferably taken over a longer time as this would allow investment in services and people. The Trust was committed to a system in which they played their part as a larger organisation as long as smaller organisations abided by their service design.

> *"We'd say we've got quite an appetite [for risk], I think. I also think one or two GPs might, but I think it's a harder ask for smaller organisations to risk share. So what we are saying is we're prepared to take a little bit of a risk, but in working with us, as GPs, they have to help us manage that risk or mitigate that risk by sticking to the pathways we agree."* (CCG1, Provider 3: Integrated Acute and Community, Manager)

An LA Commissioner in CCG2 recognized that some providers such as large acute Trusts could be more dominant than others and would not be motivated to fully engage and this necessitated commissioners' involvement: *"we need to be involved in that relationship until the providers are adult to adult"* (CCG2, Commissioner 2: LA, Director).

This interviewee also believed that LAs carried much of the risk arising from more integrated working, for example arising from the hospital discharge of patients in need of intensive support:

> *"So, you know, there are a number of reports that say, you know, there is no saving in integration, there is no business case that says integration will save you money. It might save the NHS some money, but there is always a cost shunt to the local authority, and it's just about being clear about that. We haven't quite gotten to, well, you know, quantifying that and then playing that out in our commissioning decisions around the money and whether we need to move money from somewhere else in the system to fund Adult Social Care. We haven't quite gotten to that."* (CCG2, Commissioner 2: LA, Director)

While organisations had statutory responsibilities, the development of integrated working necessitated prioritising the interests of the system over the interests of individual organisations. There was a need to think in terms of a shared risk on the outcomes that partners were trying to achieve, rather than in terms of individual risks: *"It is not my risk or your risk, it is the risk for the change"* (CCG1, Provider 3: Integrated Acute and Community, Director).

A GP Commissioner in CCG2 believed it was also necessary to focus on trust and building relationships rather than just focus on money and to persist in trying to achieve a risk-sharing arrangement.

4.5. Plans for a local Integrated Care System

While the label "Integrated Care System (ICS)" was originally used to describe a system evolving from the STP footprint, we found that the term ICS was applied to integrated working arrangements at many different levels or footprints, not only at STP level. Where CCGs had a history of successful working with local partners this helped to build relationships and provided a foundation for current initiatives.

In all three case study sites, the CCG had worked with other organisations at both local and STP levels. Integrated working changed over time in sites, responding to different policy initiatives. Organisations had most recently worked together in Vanguards in all three case studies. Nevertheless, the experience of integrated working through the Vanguard was variable with a continuation of this work in only CCG2 and CCG3. The history of working together helped build relationships and the foundation for current integrated working.

In CCG1, the CCG's recent relationships with provider partners were not necessarily amicable. The CCG and integrated acute and community Trust had emerged from a difficult relationship to work together in a more integrated way:

> *"because we've got to relearn to trust one another, having had about 18 months, two years, of being in pretty much perpetual conflict. We've now got to buddy up and sit around a table and all be mates. I feel optimistic actually, despite that slightly pessimistic analysis. But I'm not kidding myself about just how much of an ask that is. This is the same people who have basically been at loggerheads, me included, with our counterparts, having now to set all that aside and say, "OK, let's commit 100% to trusting and believing in each other.""* (CCG1, Commissioner 1: CCG, AO and STP Lead)

A Director from the integrated acute and community Trust felt that the relationship between the CCG and the Trust had undergone a change recently, with an effort by the leads of the two organisations to think in unison about the future of the population of the catchment area and how best to serve them and put in place the necessary funds. However, the CCG and Trust would need to continue to work on their relationship.

There was also a troubled relationship between the CCG and the Vanguard, arising from a difficulty in assessing the value for money of the Vanguard as freed-up capacity resulting from the Vanguard's interventions was filled due to latent demand. The issue was only resolved with intervention from the regulator. Moreover, there were tensions between providers participating in the Vanguard:

> *"The best integration works with people trusting people. And there were some people in the Vanguard, because it was being led by [GP Federation], who were using quite unhelpful language. So they'd say, "Well, we'll just stop commissioning you. We'll commission something else," instead of saying, "Come on, there must be a better ..." You know, trying to gain support"* (CCG1, Provider 3: Integrated Acute and Community, Manager)

CCG1 had a history of working together with some organisations (CCGs and providers) in the STP footprint but there was no history of all the partners in the STP working together.

CCG2 had previously worked together at a local level as an Integrated Care Pioneer pilot. The partners included the CCG and LA along with CCGs and LAs from two neighbouring Boroughs as well as the integrated acute and community Trust and two mental health and community Trusts. A subset of these partners including the CCG, LA, integrated acute and community Trust, community and mental health Trust and a GP Federation had subsequently formed the MCP Vanguard.

CCG3 had a history of working with the partners in the Vanguard. The partners started to work together following a consultation with the acute Trust about the need to meet the challenge of acute pressures and increasing demand for community care. The consultation resulted in a transformation programme that strengthened the relationship between the partners.

In terms of the wider STP, the CCGs had been working together for some time and this had helped to build relationships and trust between the partners. The STP had enabled honest conversations amongst the partners.

> *"And whilst in a way it's not comfortable having those difficult conversations, but if you don't have them, everyone moans outside of the meeting, it creates real tension between the organisations, but it's never addressed, so it can't be resolved. So for me that was a step change in our partnership working when people were willing, round the table, to say 'I'm*

> *really unhappy about this, this doesn't work for me' and that felt like a level of honesty we hadn't had before."* (CCG3, Commissioner 2: LA, Director)

In CCG3, prior to the formation of the STP, the acute Trusts had started to work together more as did the mental health Trusts in the STP footprint.

The ICS label was applied to initiatives at the CCG level, involving partners at the local footprint. Alliance agreements underpinned these arrangements, which had had their foundations in MCP Vanguards. Unsurprisingly, the ICS term was felt to lack meaning as it was being used to describe initiatives at different levels. A new organisational form to support integrated working was not foreseen in any of the three case study sites.

ICSs developed at a local level did not necessarily follow national prescriptions but were tailored to local circumstances. For example, in CCG1, the CCG and integrated acute and community Trust were developing an ICS that would cover the CCG catchment area. The Director of Finance in the Trust recognised that the approach was somewhat different to how integrated care arrangements were being operationalised elsewhere.

> *"I think that strikes me that is quite a contrast to some of the national thinking around accountable care systems and accountable care organisations where basically anybody who was in the footprint had a place at the partnership table and somebody was tasked with herding that and turning that into a set of arrangements."* (CCG1, Provider 3: Integrated Acute and Community, Director of Finance)

There were ongoing conversations about "*who were partners and who were targets*" (CCG1, Provider 3: Integrated Acute and Community, Director of Finance). Provider organisations needed to be partners in order to build integrated supply chains. Targets were organisations in other 'places' (CCGs) in the STP where CCG-funded patients from the CCG catchment area received care. Therefore, the Trust had a clear intent to repatriate work. A part of this strategy entailed a MoU between the Trust and a GP Federation focused on out-patient activity. This collaboration involved the sharing of data using electronic patient records and the creation of a single patient record.

The AO of CCG1 believed that the move towards an ICS would lead to a diminution of organisational roles and identities and "*whether it's a CCG thing or a Trust thing will become less important and it will just become a [name of place] thing.*" (CCG1, Commissioner 1: CCG,

AO and STP Lead). The AO of CCG1 believed that at some future point, legislation would confirm this direction of travel or develop it further. In the meantime, increased collaboration between CCGs and providers would develop despite the current legal framework:

> *"so in practice, we will be creating joint teams to do planning and joint teams to do performance and all the rest of it and we will probably drop out a lot of the transactional stuff. But strictly speaking, by law, there has to be a CCG. And that CCG, by law, cannot legally involve its NHS providers in its commissioning decisions. It's illegal.*
>
> *So technically we can't do any of that, because, under the Act, it is illegal. But we're just going to have to do it anyway."* (CCG1, Commissioner 1: CCG, AO and STP Lead)

In parallel to developing the ICS, the Trust and CCG were concluding a contract for the current financial year. The Director of Finance at the Trust noted that it was often difficult to recognise the context of greater integrated working in the contracting conversations, which felt very traditional and detailed. This indicated that the attitude at the top of the organisations did not always filter down:

> *"So, whilst I think the Accountable Officers certainly speak with one voice in terms of ambition and intent, I think it travels into respective organisations in different ways."* (CCG1, Provider 3: Integrated Acute and Community, Director of Finance)

The Director of Finance at the Trust believed there were issues to be resolved in order to come together in a common effort. There were attempts to change the language used, moving away from one organisation's income and another's expenditure towards a common pot of money and how to make the best of it. The CCG and Trust were exploring the idea of commissioning for outcomes rather than outputs or inputs and providing space to innovate in the delivery of services. The Director of Finance at the integrated acute and community Trust was more optimistic about the local ICS arrangements than the STP as it was much clearer to see the connection between the data and the system vision and purpose. Moreover, it was felt that focusing on a local geography gave the ICS a greater chance of success.

Nevertheless, the Director of Finance at the Community Trust felt that the CCG could learn from the STP experience of establishing governance and accountability structures in terms of

not following the path of least resistance but carefully considering the objectives for the CCG and the system and how best to deliver and achieve those objectives.

The Director of Finance at the Community Trust anticipated that as the ICS progressed all of the providers would collectively own the delivery plan for the system with a collective responsibility and ownership for delivery and performance that would be managed through an alliance agreement, rather than the creation of a new organisation such as an ACO:

> *"these guys are actually doing the sensible thing, which is, "Let's not rewrite the rule books, let's just say there's five organisations in the patch who deliver health and social care, maybe, so how do we get them to sign up to a single document, a single set of deliverables and then allocate responsibility, risk and reward however it needs to be across that system?" which, to be honest, I think is a far more sensible way of doing things, rather than trying to rewrite the rule books as Dudley is doing and creating a new organisation"* (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

In CCG2, there was some debate around the appropriate level at which the ICS should develop: the Borough level, the acute Trust footprint level or the STP level.

A Director at the integrated acute and community Trust felt there was a need to make sense of what the three levels were supposed to do and how they fitted together and worked together. This interviewee felt that the Borough level should concentrate on out-of-hospital systems including primary and community care and the interface with the emergency pathway. The commissioning of acute care should continue to be carried out at the level of the three CCGs. The STP was creating confusion by taking on too many priorities and it should be more focused on areas where it could truly add value:

> *"Then we need the STP level to back off from a whole set of things where it's confusing everybody and not adding value, and focus on two things, in my opinion: specialised commissioning, which will means changing the arrangement between national and STPs, and the big strategic programmes that genuinely cut across [place], of which [hospital] closure and [hospital] redevelopment are two examples. There should be no more than four, otherwise they're not really the big ones."* (CCG2, Provider 2: Integrated Acute and Community, Director)

In terms of allocating a whole population budget, there would be a dilemma about focusing it only on out-of-hospital services at the Borough level, or including inpatient services, which

would necessitate using the three-CCG level, which was the footprint of the acute provider. From the viewpoint of the integrated acute and community Trust, it would not be optimal to carve out the whole clinical pathway in the Borough as the Trust tended to move patients across sites spanning the three CCGs in order to avail of economies scale.

A GP Commissioner in CCG2 believed that an ICS had to be centred on a stable population that people could not flow in and out of quickly in order to be able to adequately manage the resources for that population. The GP Commissioner did not believe that STPs could readily transform into ICSs because of a lack of engagement from local authorities and also because in some areas the geographical footprint would be too large, "*But just the delivery has to be local, it has to be owned, and that's the difference for me.*" (CCG2, Commissioner 1: CCG, GP). This meant that the Borough level was a more appropriate level at which an ICS could develop, building on the Vanguard.

A Commissioner from the LA was also in favour of a local ICS at the Borough level. This would provide some traction for the CCG to prevent it being pulled in different directions such as the STP and the integrated acute and community Trust footprints.

Interviewees viewed an integrated workforce as a key component of an ICS. This would require a focus on roles, rather than organisations and a need to break down organisational boundaries.

 The Chief Executive of the integrated acute and community Trust in CCG1 highlighted that organisations tended to compete for staff, rather than for patients. Moreover, staff were the largest resource in most health systems. This meant that the health system needed to be designed to respond to staffing challenges such as staff shortages and ensuring that new ways of working were attractive to staff.

> "*So, we do need to think about how we create new ways of working, and create models that people want to work in. And it is quite a big challenge.*"
> (CCG1, Provider 3: Integrated Acute and Community, Chief Executive)

Objectives and infrastructure that supported one team rather than many different teams were seen as key enablers for system working.

Nevertheless, a particular challenge was the fragmentation of out-of-hospital services, particularly in terms of staff with GPs being independent contractors and social workers employed by the LA. Integrated working would need to break organizational barriers to bring staff and services together.

> *"Surely a logic would be to bring those out of hospital service arrangements together to create that single entity. I know it shouldn't matter that you're not on the same payroll, but it just does, because as soon as you've got different payrolls, you've got legal boundaries that then separate stuff. So, there's something about how we break down those barriers and create through new commissioning arrangements an entity that might be virtual, but an out of hospital entity that operates as one as best it can to create that continuity of care model, as opposed to the silo functional model."* (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

4.6. Future development of commissioning

We asked interviewees how they thought commissioning would develop. There was consensus among interviewees and a number of distinct themes emerged. These themes included the execution of commissioning at different levels of the system; the division of strategic and day to day commissioning roles with providers potentially undertaking the latter; and the future of clinical involvement in commissioning

4.6.1 Commissioning at different levels of the system

A clear view was that commissioning would take place at different levels of the system. This reflected the idea that services could be delivered at different scales and the right service was delivered at the right footprint.

> *"But I think we're talking about at what level, what scale is change best realised. We have been talking about STPs for a number of years now, we're now talking about places, but within places, you have got localities, within localities you have got neighbourhoods and the closer you can get to the frontline and the people and the patients; the more effective it will be.*
>
> *So, anything that moves us towards the frontline, I think is a good thing. So, if you then take that and invert it, what you have then got is right, the neighbourhood becomes king, the neighbourhood drives the locality, the locality drives the place, the place drives the STP"* (CCG1, Provider 3: Integrated Acute and Community, Director)

In all three case study sites, the two most commonly identified levels for commissioning were the STP level and the 'place' level or local CCG footprint. Services commissioned at the STP level would include specialised services as well as mental health, learning disabilities, cancer, and stroke services. A Commissioner in CCG3 felt that resources could be used more efficiently by not duplicating commissioning activity. However, strong governance structures would need to be put in place to enable commissioning at the STP level.

> *"It's not really complicated really because it's clear some things do need to be delivered at place level and some things absolutely, when we are talking about inpatient, mental health beds, it absolutely make sense for that to be undertaken at a [STP] level. So there are some real benefits. We are dealing with all the same providers and if at a [STP] level we can stop being played off against each other by having one conversation with those providers then we can get the best resources that we can with the limited resources that we have got available to spend really. For me that's a really positive approach."* (CCG3, Commissioner 1: CCG, Director)

Out-of-hospital and community services would be delivered at the local 'place' or CCG level. In CCG2 and CCG3, place-based commissioning would entail a strategic and integrated commissioning function across the CCG and LA as the CCGs were co-terminous with the LA. In CCG2, health and wellbeing boards at the locality level were beginning to undertake the planning and management of various community, public health and social services (see Section 4.1.1).

4.6.2 Strategic versus day to day commissioning

A common view among interviewees was that while there would still be a need for commissioning, this would become more strategic and less detailed on a day to day basis. While providers might take on some commissioning functions, there would still be a need for a separate planning role.

Interviewees had mixed views about whether CCGs would continue to exist in their current form. Nevertheless, there would still be a role for commissioning in terms of setting service standards and enabling services and business arrangements to be implemented.

> *"But the idea that you don't need commissioning I think is a folly. If you think about commissioning in its truer sense and the commissioning cycle of understanding need and wants, which policy, what evidence works, who might provide and deliver services, what the public think of it, how you co-*

produce all of that, you know? You're going to have to do all those functions if you want things to be better. I think too often people think commissioning is contracting." (CCG3, Provider 1: Community and/or Mental Health, Chief Executive and STP Lead)

There was a need for commissioning to *"become an enabling functionality rather than a contracting functionality"* (CCG1, Provider 3: Integrated Acute and Community, Director of Finance).

A Manager in the integrated acute and community Trust viewed CCG1's current application of commissioning as too detailed and it needed to evolve to become more strategic.

> *"Certainly in our area, there's been an insistence from the CCG to be too worried about what we're doing as providers in detail, rather than say to us, "We want a four-bedroomed house with two bathrooms and a garage, thank you." That's what they should have been able to do and draw a picture of what that four-bedroom house would roughly look like. Give us the picture, we go away and make it happen.*
>
> *They've been too worried about what are our staffing ratios, what are our ... They should be worried about what are our outcomes.*
>
> *Have we built the house? Has it got two bathrooms? Is it falling down? You know? That's what they should be asking themselves."* (CCG1, Provider 3: Integrated Acute and Community, Manager)

It appeared that CCG1 were starting to move in this direction as a GP Commissioner believed CCGs would take on a strategic commissioning role with longer-terms contracts and outcomes-based commissioning.

Interviewees also discussed the potential role of providers in commissioning. A number of providers expressed an interest in taking on some commissioning roles, yet recognised that they could not totally subsume a CCG's functions, underlining the need for a separate commissioning function, particularly in terms of planning and setting of outcomes.

The Chief Executive of the mental health Trust in CCG3 believed that as commissioners developed a strategic role, some day to day commissioning functions would be sub-contracted to providers, working in collaboration. This would enable providers to have a clear picture of expenditure, activity and quality of services. A Commissioner in CCG2 agreed that providers could undertake some commissioning roles in terms of service or pathway redesign. The Chief

Executive of the integrated acute and community Trust in CCG1 felt these roles could be delegated to providers using innovative contracting models including lead provider models.

The Chief Executive of the integrated acute and community Trust in CCG3 believed there would be consolidation of providers with structures such as the joint committees of providers at the STP level becoming legal entities as single provider of services (such as acute, community or mental health), funded with a capitated budget. However, this interviewee did not have a clear idea what would happen to primary care and outpatient services in this scenario, nor how this fitted with place-based care. The need for consolidation of providers was built on the belief that there were too many NHS organisations leading to large transactions costs and the need for regulators such as CQC and NHSI. The Chief Executive believed it was unnecessary to have both regulation and commissioning and as STPs could undertake some performance management roles alongside NHSI, there would be no need for commissioning and CCGs.

This view was not shared by other providers, who believed there would still be a need for a separate commissioning role.

The Chief Executive of the mental health Trust in CCG1 underlined the need for planning and strategic commissioning and providers do not necessarily have these skills

> *"If you look at some of the elements of commissioning, that is being objective, using information more and better, trying to really understand the outcomes and using that to change services. Well, all of that is what you have to bring into accountable care arrangements and, personally, do I feel that provider Trusts have got all that knowledge and ability? No.*
>
> *We haven't got the wherewithal to say to some of our clinicians 'just stop doing more of this', we're not as good as we should be, our governance arrangements and looking at outcomes. So, as we move to accountable care arrangements and STPs, if that's about bringing commissioners and providers together, even if, technically, CCGs get wiped out, you've got to make certain, in those new arrangements, that you've got the good bits or the important bits of commissioning inside those new arrangements."* (CCG1, Provider 1: Community and/or Mental Health, Chief Executive)

Both commissioners and providers anticipated that increased integration would lead to a return of an arrangement akin to the health authorities that had previously existed.

The AOs of both CCG1 and CCG2 referred to these arrangements at the STP level. The AO of CCG1 believed these 'health authorities' would consist of divisions organised at a lower level, such as an LA footprint. Commissioners would evolve into the planning and performance management division of the health authority. The AO of CCG2 believed that such a configuration would bring commissioning together with the assurance roles of NHSE and NHSI at the STP footprint.

4.6.3   Clinical involvement in commissioning

Interviewees shared their views about clinical involvement and leadership in commissioning. Both commissioners and providers agreed that clinical involvement and leadership in commissioning was important but felt that this would evolve from the original vision of the HSCA 2012.

Commissioners from CCG2 expressed strong support for clinician involvement in commissioning. A GP Commissioner from CCG2 was convinced that clinicians needed to be involved early in the process, specifically before concentrating on the contractual side of commissioning. The AO of CCG2 noted that the STP had started to support clinicians to take on additional roles to transition into the new configurations.

A Director from the community and mental health Trust in CCG2 believed GPs had a strong ability to challenge providers and stressed the need to retain the clinical element of commissioning:

> *"We've had some very strong clinical commissioners, particularly around mental health, some really well informed and knowledgeable GPs who have been the advocates for mental health within the commissioning system, but who've also asked us as an organisation, some tricky questions and as a consequence we provide better services. I think, you know, if we do end up in a system where ... which collapses commissioning and provision into a single structure of some sort, we need to think about how we maintain that grit and that challenge."* (CCG2, Provider 1: Community and/or Mental Health, Director)

A Commissioner from the LA in CCG3 also had a positive view of clinical commissioning but felt that it focused too much on primary care, with little role for secondary care.

> *"So clinical commissioning is brilliant, absolutely fantastic, absolutely what we need. I don't think you can do any effective commissioning without it being led by clinicians. And my whole team work brilliantly with secondary care clinicians. But then that's another concern for me around some of the CCG stuff is that whilst there needs to be rightly a focus on primary care, it feels like where's the voice of the secondary care clinician? Because from my experience, limited experience, when I've made real change it has been led by a secondary care clinician."* (CCG3, Commissioner 2: LA, Director)

While interviewees viewed clinical involvement in commissioning as advantageous, there were suggestions that clinical leadership in the form of CCGs would need to evolve in response to increased partnership working.

The Chief Executive of the mental health Trust in CCG1 felt that while clinical involvement in commissioning was beneficial, clinical leadership in the form of CCGs was not altogether compatible with STPs:

> *"you look at the language that was around with Andrew Lansley, it was all about aggressive commissioning in the hands of GPs will improve the NHS. And I think there are very, very few people left who believe that to be the case. Getting GPs more involved is always a good thing, giving them a better understanding of the commissioning and arrangements is a good thing, but giving them complete control means you've stopped any element of central planning and STP planning."* (CCG1, Provider 1: Community and/or Mental Health, Chief Executive)

The AO of CCG1 felt that while clinical leadership was still important and integral to a system approach, GPs and other clinicians would be asked to plan health and social care in collaboration with social care professionals rather than commission care in the way envisioned under the HSCA 2012 or previous approaches such as GP fundholding.

> *"But I don't think we'll use the transaction of saying to GPs, "There's the budget for secondary care. You buy what you want from the hospital and keep the balance.""* (CCG1, Commissioner 1: CCG, AO and STP Lead)

4.6.4   Commissioning by LAs and personalised commissioning

Interviewees highlighted the benefits of commissioning by LAs and personalised commissioning.

A Commissioner from the LA in CCG3 believed that LAs were strong commissioners and some parts of health care commissioning such as primary care and community services could move to the LA while other parts such as acute care and workforce could go to the ICS. Nevertheless, this interviewee recognised the challenges of NHSE handing over some commissioning responsibility to LAs, despite potential benefits:

> *"well I don't think NHSE in a million years would let any primary care commissioning come into local authority if I'm honest, but because the NHS is so political and so centrally involved, that would be quite a big clash with local authority, and you'd have to work through some of that. But potentially it could be amazing. Local authorities have made their budget cuts whereas NHS haven't. So there's something to be said for ... and also local authorities are brilliant at commissioning and procurement, so they're much tougher with providers than I see the CCGs being."* (CCG3, Commissioner 2: LA, Director)

There was also the question of the extent to which commissioning would move to people, for example in the form of personalised budgets. A drawback of these was the administration costs. However, the AO of CCG2 felt that personalised budgets were the only way to integrate NHS and LA funding:

> *"I suspect what we'll do is we'll go down a route and try and pool everything, and then it will probably be difficult because risk share, you know, the reality is the way local authority money streams is very different to health. And I think that's always going to get in the way. And I think that's okay. I think we should just really acknowledge that. But certainly, it would make a lot of sense to try at least. And the only thing that will bring that together is when you've got more personalised budgets held by the client or the patient."* (CCG2, Commissioner 1: CCG, AO and STP Lead)

5. *Discussion and conclusions*

5.1. **Summary of findings**

This study aimed to investigate how CCGs have responded to recent developments in the commissioning system in terms of their decision-making processes, role in the wider health system, accountability, and use of commissioning levers. We also explored participants' views on the future development of commissioning.

We asked CCG interviewees about whether CCG internal processes of decision-making had changed in response to changes in the commissioning system. CCG decision-making processes

and structures were starting to change in response to changes in the wider commissioning context. While GP involvement in the CCG GB was unchanged, there was some evidence that CCG GB decision-making was becoming more strategic. GPs were still engaged in decision-making at the locality level, which indicated that GP involvement in decision-making could be maintained at different levels. The daily issues confronted by CCG management had not changed greatly, centring on finance, quality and system recovery. CCG GB sub-committees played a role in formulating CCG priorities. CCG priorities were increasingly informed by partnership working.

We explored the role of the CCG in the changing commissioning landscape. CCGs participated in governance structures at the local CCG level with the LA as well as a wider set of partners. CCGs recognised that their statutory functions were exercised in the context of wider system working. CCGs explored ways to work jointly with neighbouring CCGs in order to align strategies and streamline collective decision-making. There was variability in the development of STP governance structures across the case study sites. CCG AOs took on the additional role of STP Lead in two of our case studies. A lack of statutory status limited the decision-making powers of STP structures. One CCG had a history of working with organisations from a different STP footprint, which complicated matters. The introduction of STPs placed some strain on these relationships, as some organisations perceived the CCG was not fully engaged in the second STP. Another problem in the early development of STPs was inadequate engagement of LAs. While organisations were not compelled to participate in STPs there were incentives for them to do so, particularly as STPs assumed greater responsibilities for example, in relation to transformation funding and estates prioritisation. Coordination between different levels was achieved primarily by STPs adopting the principle of subsidiarity as well as building on partners' existing governance structures and programmes of work.

Given the complexity of the commissioning environment, CCGs had to maintain vertical accountability, both upwards to the national regulator and downwards to CCG members and the public as well as horizontal accountability to other commissioning organisations and local partners.

Horizontal accountability proved challenging for all organisations. The non-statutory nature of collaborative initiatives such as STPs and Vanguards meant that decisions were referred back to Boards of individual organisations. Moreover, there was no equivalent to a CCG AO or

provider Chief Executive who could be held ultimately accountable, despite the fact that STPs had a lead individual. A significant challenge arose in designing joint accountability structures. Informal arrangements (such as conversations between Chief Executives) played as important a role as formal structures. Interviewees discussed the need for mutual accountability and peer review, with partners accountable to each other rather than to a single lead or external regulator. This would require partners to share information (either formally or informally) while a key role for the STP (or ICS) would be to set system-wide targets. The design of accountability arrangements was easier in systems with fewer organisations.

Interviewees from both CCGs and LAs highlighted the different perceptions of accountability in the respective organisations. While LAs derived democratic accountability from local populations, CCGs responded to top-down accountability from NHSE.

Neither CCGs nor providers felt themselves accountable to the STP, primarily because they were statutory organisations while the STPs were not. Accountabilities remained to the regulators, Boards, and local publics. Nevertheless, there was a perception that the regulators viewed STP Leads as accountable for the performance of the whole STP. The non-statutory nature of STPs meant that STP Leads were limited in the exercise of their authority, relying primarily on personal relationships and peer influence.

CCGs upward accountability remained to NHSE, with increasing involvement of NHSI in the context of closer working between the regulators at a regional level and a willingness to exercise their functions in conjunction with STP leadership. CCGs also continued to undertake engagement with the public and GP members.

In light of the move towards increased collaborative working, we explored the relevance of competition and pricing to commissioning decisions and the effect of these on integration. Interestingly, we found a divergence in opinion on the use of competition between CCGs and LAs. While CCGs were unanimously in favour of less competition, LAs did not necessarily agree with this position. This difference in attitudes largely stemmed from the different markets for health and social care. In healthcare, a small pool of providers competed for large contracts while the market for social care was comprised of a larger number of small providers, many from the third sector. In contrast, CCGs were in favour of moving away from competition, as they did not believe it was useful for facilitating integration and providers needed to collaborate

to address system challenges. CCGs tended to use competition the margin or to stimulate the market. Interviewees discussed drawbacks of competition in terms of transactions costs and fragmentation of services but recognised that competition could drive efficiencies and it would be a challenge to retain these benefits in collaborative working. Commissioners used competitive dialogue to procure innovative contracts such as alliance or lead provider contracts.

Interviewees expressed a desire to move away from the use of different payment systems for providers as this inhibited an alignment of resources and hindered integrated working. There was a consensus that PbR was an impediment to collaborative working, as it concentrated resources in acute providers and did not incentivise integrated pathways. Nevertheless, both commissioners and providers acknowledged benefits of the national tariff in terms of understanding the costs and value of activity and suggested it could be kept as an internal costing or benchmarking mechanism for providers. One interviewee from an acute provider was vocal in opposing payment reform, advocating clinical redesign as a first step. Both commissioners and most providers were keen to move towards payment that would support integrated working, such as capitated budgets. One CCG had succeeded in moving to a block contract for the main acute provider. The contract incentivised shared savings and was key to returning the system to financial balance. Providers of community and mental health were particularly critical of PbR as they had to absorb increased demand in light of payment by block contracts. Collaborative working and the alignment of resources between providers by moving to a common payment system was thought to help to address system financial challenges.

Alliance contracts were in operation in two of the three case study sites. Negotiation of alliance contracts was challenging, given the need for efficiencies. These contracts often involved shifts in activity between organisations and providers expressed a readiness to cede control of services if a different partner or reconfiguration of services could deliver services better. Nevertheless, there was some evidence of competition for services between organisations, which could impede alliance working.

We also sought information on attitudes to risk-sharing in general and to what extent risk-sharing was undertaken in practice. Overall, interviewees expressed positive attitudes towards risk-sharing but also highlighted the challenges, particularly for systems with a larger number of partners or those with financial challenges. Two of the case studies had acute providers with large PFI debt and interviewees called for national recognition and ownership of this financial

challenge. Additional challenges arose from the relative size of an organisation and the capacity to bear risk, and the ability to put the system interest over the individual interests of organisations.

We also gained insight into the development of 'Integrated Care Systems' (ICSs) in our case study sites. While the term 'ICS' was originally used to describe a system evolving from the STP footprint, interviewees applied the term to integrated working arrangements at many different levels or footprints. Given its generic application, many interviewees felt that the concept of an ICS lacked specific meaning.

The ICS label was applied to initiatives at the CCG level, involving partners at the local footprint and building on MCP Vanguards. Alliance agreements underpinned these arrangements and a new organisational form to support integrated working was not anticipated. Interviewees emphasised the importance of roles, not employer organisations in developing an integrated workforce.

Finally, we sought interviewees' views on how commissioning would develop. There was general uniformity of opinion and several common themes appeared. Given the ubiquitous nature of integrated working at both STP and CCG footprints, it would be inevitable that commissioning would be discharged at these levels. At the CCG level, commissioning would be integrated with the LA. Commissioning would also become strategic and providers could discharge some of the day to day aspects of commissioning. However, both commissioners and providers recognised that while commissioning might not necessarily endure in its current form, there would still be a role for commissioning as an activity, particularly in terms of strategic planning. Interviewees highlighted the benefits of clinical involvement in commissioning and supported its continuation.

5.2.   Limitations of the study

The study has certain limitations. *First*, as the study design consisted of three in depth case studies, it is not possible to make statistically based generalisations to the whole NHS. Nevertheless, we have been able to give a detailed account of how the new commissioning system is developing in three areas. *Secondly,* in order to maintain depth of focus, we mainly considered recent developments in commissioning from the perspective of an individual CCG, not a whole STP area. This means that we limited our data collection to the local CCG. *Thirdly*,

our case study CCGs were partners in STPs being led by individuals from NHS organisations. LAs lead a small number of STPs and while we approached a CCG in one of these STPs, they did not have capacity to participate in this study. There might have been a different approach in these STPs.

Importantly it must be recognised that the commissioning system is in a transitional phase and this research presents a snapshot of developments at a relatively early stage. There is a need to continue to track the progress of the development of STPs and ICSs, especially in light of a new ten-year plan and new guidance on pricing due for publication in the third quarter of 2018/19, as well as a consultation on the contract for Integrated Care Providers (formerly Accountable Care Organisations) (NHS England, 2018a) running from August to October 2018.

5.3.   Conclusions

Integration of services is receiving major attention at local level. Relationships and trust underpin increased collaborative working while formal organisational structures appear to be less important. None of the case study sites were precipitating a new organisational form to advance integration; rather sites were availing themselves of contractual forms such as alliance agreements. The case study sites were not following a uniform approach to integration and even within sites the approach to collaboration changed over time, reflecting various policy initiatives. Nevertheless, sites adopted their approaches to local circumstances, either by building on the work of the Vanguard and including all local partners, or concentrating efforts initially on partnership working between only two organisations such as the CCG and an integrated acute and community provider. A common element in all three case study sites was that integrated working was focused on the CCG footprint; and that changes are being led by detailed joint work between individuals at local level, rather than by making structural organisational changes. Personal relationships and taking sufficient time to develop trust through repeated joint working were vital.

Integrated working between CCGs and LAs is also a central component of collaborative working. However, important cultural and structural barriers to integrated working between CCGs and LAs need to be addressed. These include different attitudes and cultures, for

example in relation to accountability and competition, as well as different funding streams and eligibility requirements.

The notion of an STP is starting to have salience in the NHS, and it is building on, rather than replacing existing more local collaborations. Partners used STPs for activities that benefitted from economies of scale. A key strategy to coordinate integrated working at local CCG and STP levels was the adoption of the principle of subsidiarity by STPs. STPs recognised the structures and work being undertaken at the CCG level and did not seek to replicate or substitute for this work, but rather to complement and build on local initiatives. Thus, there is a need to recognise that STP development needs to go with the grain of previous partnerships, and to allow local systems to undertake changes at the appropriate level. STPs need to concentrate on changes which require a larger footprint.

It is clear that commissioners and providers are investing significant effort into developing integrated systems. This has implications in terms of accountability, provider payment, risk-sharing, data systems and workforce. Major barriers, such as organisational boundaries and the pricing regime of the internal market need to be overcome. The new direction on pricing expected from NHSI and NHSE will be important in allowing local systems more latitude in how to use incentives.

Governance structures at various levels are complex and it is unclear how they relate to each other, apart from the CCG being an important component of each. Governance is complicated by the limited power of collaborative Boards and structures due to their non-statutory nature. It is difficult for organisations to delegate the appropriate degree of decision making to the various committees involved in collaborative working. This also means that accountability is challenging as full accountability cannot be delegated to a single leader or Board. While CCGs and providers did not feel directly accountable to the STP as an entity, this relationship was nuanced with a recognition of a moral accountability as well as accountability for providers arising from CCGs' seat on the STP Board. Systems were developing arrangements for mutual accountability and peer review. Trust and the sharing of information are vital to the success of such arrangements. STPs that aspire to become ICSs will need to continue to develop accountability arrangements as there is potential for ICSs to operate under a more autonomous regulatory regime (NHS England and NHS Improvement, 2018).

Integrated working presents an opportunity for a more balanced allocation of resources across the system. Nevertheless, the use of different payment approaches for different providers impedes the efficient alignment of resources. The move to different types of payment systems such as capitated budgets and outcome-based payment is starting. While there may be some resistance to reform of current pricing rules, our data shows a willingness on the part of providers to implement innovative payment systems across a system. As mentioned above, new national guidance is expected shortly in respect of pricing. This will be important in facilitating innovative uses of financial incentives at local level. A potential new payment approach could blend elements of block contracts and activity-based funding in order to retain the benefits of both (Dunhill, 2018b).

There is a need for national oversight and assistance to form and develop risk share arrangements and mechanisms. This could take the form of an organisational layer between NHSE on the one hand and STPs and ICSs on the other. Moreover, the size of debt held by some organisations, particularly acute Trusts poses a serious impediment to risk-sharing. There is a need for a way of implementing the notion of 'shared ownership' of debt as it does not make sense for organisations to be held individually responsible for financial performance in the context of integrated working.

It is clear that the regulation of organisations as separate entities was a barrier to organisational collaboration and risk sharing. One development which may reduce some complexities in respect of regulation is that the regulators themselves are being reorganised. The policy direction is that the regulators NHSE and NHSI will be integrated and that there will be a regional level regulation, instead of only a national level (NHS England, 2018b). Moreover, there is a move for regulatory powers to be exercised in conjunction with ICS leadership (NHS England and NHS Improvement, 2018).

Scale is important for service delivery. Key aspects of integrated working such as accountability and risk-sharing are easier to address in smaller systems, particularly if all organisations are fully included in the footprint. Integrated working becomes more challenging when organisations bridge geographical boundaries, for example if a CCG is not co-terminous with a LA or the footprint of an acute Trust spans several CCGs. This explains why the primary focus on integration is on the local CCG level. This is another reason why STPs adoption of a policy of subsidiarity is sensible.

Interviewees highlighted a number of areas for improvement to expedite integrated working. While senior managers favoured closer integration between organisations, it is clear that the interorganisational level may not be the most salient issue. It is important that staff engaged in the administration and delivery of services have the ability and motivation to implement these plans. Importantly, not all the issues are regulatory or organisational. Interviewees also spoke of challenges relating to the integration of data systems and the workforce itself, as well as the adherence to and interpretation of the legislative framework.

Clearly commissioning is in a state of flux and will continue to evolve, particularly in response to future developments[4]. Irrespective of how the current policies of place based integrated care develop, there will always be a role for planning, and thus a degree of commissioning in the NHS, as a publicly funded system. Strategic decisions need to be made about the allocation of public resources between different services in order to optimise population health and wellbeing. Our results point to a system in which the strategic planning element of commissioning will be implemented at the local place (CCG) level, in conjunction with the LA as well as the STP level. It is important that the detailed specification and monitoring of individual services is also maintained in order to ensure accountability and this may be undertaken by other bodies (possibly lead providers of networks of sub-contractors or alliance contract parties). These fundamental tasks of service planning and monitoring are essential to an effective healthcare system, whether they are labelled 'commissioning' or not. Finally, it is important that commissioning continues to avail itself of the benefits of clinical involvement. But it is unlikely that the vision of the HSCA which put GPs as the centre of commissioning will endure the current system changes.

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[4] A ten year plan will be published by NHS England in the autumn of 2018, outlining the key areas where the increased health expenditure announced in June 2018 will be targeted. The regulators will publish new guidance on pricing, which will reflect the financial arrangements outlined in the ten year plan. In August 2018, NHSE launched a twelve-week consultation on the contracting arrangements for integrated care providers (formerly Accountable Care Organisations). The consultation will inform NHSE's plans on whether the draft ICP contract should be further developed and if so, how it would be developed.

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