**THE KING’S FUND – THINKING DIFFERENTLY ABOUT COMMISSIONING.**

 **VIRTUAL CONFERENCE/WEBINARS 15th- 18th MARCH 2021.**

**OBJECTIVE:** To update and discuss the new role of commissioners within Integrated Care Systems (ICS’s), particularly following the publication of the recent Government White Paper.

**DURATION**: Four mornings (10.00 to 13.00) from 15th to 18th March 2021.

**Delegates:** Approximately 400 attendees from all sectors connected with health service and ancillary organisations.

**Slides accompanied most of the presentations**.

**DAY ONE – session one. Setting the Scene.**

**Welcome, Introduction & Chair** – Ruth Robertson – Senior Policy Fellow – The King’s Fund.

**Keynote address** – Evolving clinical commissioning – Louise Patten, Chief Executive, NHS Clinical Commissioners.

CCG’s moving from LA to ICS responsibility. Services will be patient centred. ICS’s will encompass all health service providers including Pharmacies, Dentists, Optometrists, etc. ICS’s are NHS controlled bodies but all partners come to the ICS equally.

ICS’s to be operational by the April 2022 deadline, so boards need to be in place by September 2021. ICS’s will be built on the best of the current commissioning.

**Key challenges** for commissioners and learning from experience – Dr David Hambleton, Director, DH Leadership Alliance.

Great role models for ICS’s – South Tyneside, City of York (place based model) & Canterbury NZ.

Challenges for the new approach. Improving population health. Behaviours of people will influence what is delivered. Commissioners must listen to people. Commissioners should be responsible for the health of the system. Definite culture change. Team players. Shared purpose and language. Doing it differently in the new world. Must think collaboration.

**Q&A session for these two presentations.**

Changes will cause some disruption. Actions will be at ‘Place’ level. Shift from contract enforcers to enablers. Commissioners and Providers to have conversations on how best to prioritise opportunities. Commissioners need to talk systematically to the community and patients, to ensure they are fully involved. Commissioner responsibility to ensure Patients and Carers can influence decisions. Charities and Voluntary Organisations should ensure that they are on the ICS Stakeholder List so as they can work with ICS’s. CCG’s have public meetings so Charities and Voluntary Organisations should attend to make their voices heard. NHS must financially support LA’s.

**DAY ONE – session two. Joint Commissioning for Place–Based Working.**

**Introduction & Chair – Lisa Gibson – Strategy & Development Manager, Health Partnerships, Leeds City Council.**

**Developing an Integrated Approach to Commissioning:** Sharing the Oldham Story – Mike Barber, Strategic Director of Health & Resources, Oldham Council & CCG.

Oldham is a part of the highly successful Greater Manchester ICS (“Devo Manc”) which has been operational for around 5 years. Inequality in the community is a massive problem. Their commissioning system has just one commissioning function & a single accounting officer. It has been working with schools, housing and police to effectively create Social Prescribing (Focus Care) for about 3 years. Whole System Model of Care which is an

integrated care model with blended leadership. In summary, it is Population, Health Planning and Delivery. Oldham connects well with Greater Manchester ICS. Now considering impact of Government White Paper for the next generation of the Oldham integrated model. Parliamentary approval of the White Paper expected this summer.

**Building Healthy Communities**: a Place-Based Approach to Joint Commissioning in Leeds – Tim Ryley, Chief Executive, Leeds Clinical Commissioning Group.

Leeds has commissioning responsibility for about 900,000 people. Improve the health quickest for the poorest people. He gave an example of ‘Jack’, who had benefitted massively from Local Care Partnerships (LCP) and Population Health Management (PHM), which is the process of improving clinical health outcomes, for a group of individuals through improved care coordination and patient engagement, supported by appropriate financial and care models. Citizen Level Costing. NHS and LA procurement will be combined.

**DAY TWO – session three – Population Health Management & The Role of Commissioners.**

**Introduction & Chair – Harry Evans**, **Senior Programme Lead, Primary Care & System Transformation, NHSE.**

**Shaping Our Future**

**(a)Lucy Jackson, Chief Officer, Consultant on Public Health, Leeds City Council.**

A key component of the integrated frailty framework is an early assessment of the frailty of the Leeds population. Leeds have a Population Health Management system (PHM) which is at ‘Place’ level. Enabling Local Care Partnerships (LCP) is what matters to people.

**(b)Rebecca Barwick, Head of Pathway Integration, NHS Leeds CCG.**

Outlined briefly the Leeds Health & Wellbeing Strategy. NHS Leeds CCG has identified strategic commitments but still not delivering the long term improvement plans in the community. NHS Leeds CCG has an operating model with plans started in 2020 and then more for 2021. It will succeed as competition develops into collaboration. It will be person centred integrated care. There will be new requirements at ‘place’ level, once CCG’s, in their current format, are abandoned.

The challenges include: How to balance the new approach to commissioning to actually delivering. Assessing how good their data is – this has been tested for ‘frailty’ and found to be good but generally data quality isn’t good e.g. Adverse Childhood Events, as data is held by the LA, the Police, but not specifically in their systems. How to reduce health inequalities, thus improving outcomes.

Place and partnerships with a Health & Wellbeing Board will be ‘place’ centred and will ensure communities are involved. Money will be channelled into the new system. Communication to the community is critical via Population Health Management. Health Watch will also be critical to the programme as they work with the community.

Q&A session.

**DAY TWO – session four. Shaping Clinical Leadership fit for the future of commissioning.**

**Chair – Leo Eubank, Policy Researcher, The King’s Fund.**

**A new approach** and set of values for clinical leads with Leadership Skills - Dr Mark Shenton, Clinical Lead, Suffolk and N.E.Essex ICS.

Shaping clinical leadership fit for the future of commissioning. Strong leadership is critical. ICS staff should be trained as teams, not individuals. Suffolk University now has a very successful course covering ICS structure and implementation.

**Engaging Clinicians** and empowering them to create change- Dr Sian Howell, GP, NHS Southwark CCG.

Sian Howell is part of ‘Clinical Effectiveness Southwark’ (CES). Their aim is to reduce variation across the community and have consistency. The culture must be correct and appropriate. Ensure that change moves at the speed of the Trust. Make the right thing to do, the easy thing to do.

Q&A Session.

**DAY THREE – session five – Commissioning Collaboratively with Providers.**

**Chair – Leo Eubank, Policy Researcher, The King’s Fund.**

**The Changing relationship** between commissioners and providers – Paula Head, Senior Fellow, Policy, The King’s Fund.

Historically, did independent providers improve purchasing? Quality may or may not have impaired competition, which helped initially. ‘Systems Commissioning’ will need education and support. Total need for collaboration for better wellbeing and health to be achieved. If commissioners and financial objectives are brought together then it should work and will make a positive difference. New duties include: collaboration, systems financial objectives, better health & wellbeing for all, sustainable NHS providers. Recovery from the pandemic must ensure that mental health needs are understood.

Education and support is needed for commissioning. The Southampton NHS Model and the Wessex Model are excellent case studies demonstrating rapid integration of services. Created a virtual programme for cancer diagnosis resulting in improved referrals. Primary care providers combining with commissioners and other providers shows that anything can be achieved.

**Provider collaboratives to improve services** – Sean Duggan, Chief Executive of Mental Health Network, NHS Confederation.

ICS’s to include mental health but what models are there and what is good practice. Mental Health works well in the UK but has under investment. We’re just reaching the end of a five year plan and a good framework was set out for commissioners and providers. There’s now a new long term plan which is Government backed and funded with a framework with milestones and targets, which begins immediately. It takes users and carers as a priority (Co-Production). Improvements are needed and Service User Groups are enthusiastic for change.

The ICS model is developing well, setting up alliances, partnerships and collaborations. Provider collaborations have been working well for a couple of years in mental health. Critical to get mental health users out of hospital back into the community in conjunction with housing partners (independent sector and voluntary sector). Models are now formally set up including specialist services, e.g. eating disorders, as part of the collaborative. Legislation for mental health is part of collaborations and ICS’s are being implemented following the pandemic.

Place based ICS’s linked to LA’s and working with the voluntary sector is essential. School based mental health services are also essential. The main risk is workforce deficiency, but increasing the workforce is essential. The effective system capacity for mental health must be examined.

**Q&A Session for these two presentations.**

Examples of commissioners and providers coming together. Primary success factor is based on patients’ needs - difficult decisions must not be avoided. A care pathway for diabetes showed that amputations had been reduced significantly in a two year period through collaborations in Southampton NHS FT.

Provider collaborations in mental health are essential. Examples – better outcomes for patients being released from hospital and then being helped back into a job. A reduction in children being in mental health units hundreds of miles from home – collaborations reduce this occurrence, which is critical for the child and the family.

As the NHS landscape changes with the advent of ICS’s, these changes will not be easy, but honesty between collaborators is essential.

**DAY THREE – session six – Emerging Trends in NHS Financial Architecture.**

**Chair/Welcome/introduction – Siva Anandaciva – Chief Analyst, The King’s Fund.**

**Gary Andrews – Head of Payment Policy – NHSE/I.**

Capital Project Funding will be controlled by each ICS. Relationships will be essential for successful System Collaborations.

**Tarryn Lake – Associate Director of Finance – NHS Sunderland CCG.**

The Sunderland programme (Vanguard) has lifted the burden of transactional contracts. Block contracts previously. Now payment on outcomes. There is still work to do on reforming contract payments.

To help reduce health inequalities there will be a flexible payment system. Benchmarking will be needed for payments.

Empower our leaders and our developing leaders. Recognise changes will take time. The payments system will change part way through 2021/22/.

**Q&A session for these presentations:**

Out of Hospital Alliance will help take pressure away from other services.

System Leadership is needed at every level, not just directors.

Less time on contractual disputes – more focus on patients.

The new financial architecture will also involve LA’s, primary care and voluntary sector. Budgets will be pooled as far as possible to maximise the amount that goes into the central pot.

How long will it take to have ‘place’ being part of the pooled budget? ICS’s are at different stages of the journey, so this will happen at different times. The speed in achieving pooled budgets will depend on individuals.

Section 118 to be considered soon and this will be agreed between commissioners and providers. Contracts will be between ‘Place’, ICS’s and providers.

**DAY FOUR - session seven – What does the future hold for commissioning?**

**Chair: Professor Dr Durka Dougall – Senior Consultant & Programme Director, Leadership & Organisational Development, The King’s Fund.**

**Commissioning for Complexity –** Dr Toby Lowe, Visiting Professor of Public Management, Centre for Public Impact.

Leadership is critical. Commissioners should be challenged on how they identify key questions and are they continuously exploring ways to find new answers. How do commissioners share information? How are patients involved in this process and how can we learn alongside them.

Plymouth Alliance was given as an example where there is a 10 year, £80m commission for adults with complex needs. A new approach – Alliance contracts. No targets or KPI’s. Organisations just learn together which builds trust. By way of measuring just part of the success of the programme, emergency accommodation costs were halved in just six months. Better outcomes for citizens.

**Commissioning in the new emerging ICS structure** – Amanda Sullivan, Chief Officer, Mid Nottinghamshire CCG.

Redefining commissioners – new commissioning provides dynamic mutuality – new commissioner/provider dynamic, mutually accountable for population health, quality and use of resources.

Traditional market management moving towards support for the whole system to develop into effective delivery units (places and populations).

**Reflections on the future of an evolving sector** – Professor Dr Durka Dougall.

The role of Public Health is essential in improving the populations’ health. Need to consider trends, effects of Covid-19 and inequalities. Work must include health prevention, promotion & protection. We must effectively connect to communities. Robust training will be required. We need well-led organisations.

**Q&A session.**

Everybody needs to engage in interactions. Competition will evolve into collaborations. Governance is less important. Contracting skills will continue to be essential but need to be repurposed to meet the new scenario.

End of Webinars.

**Summary/Conclusion.**

The recurring themes through these presentations include: ICS’s, collaborations and alliances are now the norm – all should improve health outcomes, of course. Place & Patients are the basis for collaborations. The current myriad of CCG’s will be replaced by one CCG within an ICS. CCG’s will become contract enforcers to enablers. All health services will become part of an ICS’s. Strong leadership & training at all levels is critical. Health prevention & promotion is a priority, Team players. Mental Health is paramount and continues to be positively addressed. The voluntary sector and charities will still play a critical role in ICS’s.

The ICS’s highlighted in presentations were positively presented but even those which have been operational for four or five years still have more progress to make with consolidation of some services still required.

The aim is to have all collaborations/alliances fully operational as ICS’s by April 2022. Is there sufficient time for a seamless change? Time will tell.

**Helen Graham**

**March 2021**