Lancashire and South Cumbria as a New Commissioning System: **The Journey So Far**

Healthier Lancashire & South Cumbria

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Executive Summary

August 2018 marked a one-year milestone in Lancashire and South Cumbria's journey towards a new commissioning system. This article describes that journey, focusing on the lessons learnt in the first year of what will ultimately be a long-term plan for change.

Key to Lancashire and South Cumbria's experience is the importance of putting the right people alongside the best processes and using the most honest approach to get reform in a complex and multi-faceted system successfully off the ground. We talk about the importance of buy in and co-production as well as the need for clear project design and the incorporation of bespoke ways to make decisions based on data and evidence as well as passion and governance.

Our work highlights that four key principles are crucial to initiating a successful system reform programme. These are described below.

Principle	Experience	Learning
1. Gaining meaningful buy in to an initial proposition from those who will be key to success is absolutely critical.	The initial scope of work set a limited, incremental ambition that proved to be unhelpful in the pursuit of whole system change. It was reviewed to support a more whole system approach. The design of the approach was entrusted to a local leadership team, initiated to drive the work forward. They were credible, passionate and prepared to 'learn in action'.	Be clear about intentions right from the start and test the goals and expectations repeatedly with stakeholders and influential thinkers. Deploy the right leadership team with the talent and skills to focus on people primarily, supported by processes.
2. Using co-production to develop any new model or way of working yields the strongest commitment to make things work, despite uncertainty or challenges in implementation.	A commitment to engagement and iterative design was offered from the outset and was enacted through workshops and partnerships with local experts. The ability to propose ideas and test applications enabled the development of a model that felt relevant and feasible instead of purely theoretical or impossible to achieve.	Invest time, energy, resource and reputation in the co-production of a new way of working in a complex system. The sense of co-design and co-development fosters a problem solving will to do the right thing.
3. Designing and applying a bespoke, relevant and objective decision-making tool when decisions are contentious or critical adds science to art and enables progress when progress might otherwise get stuck.	Some decision-making criteria and a decision-making tool were adapted and applied to enable commissioners to test the model against real functions and responsibilities. The testing approach gave the model credibility and the outputs enabled recommendations for the model in practice that may otherwise have stalled.	A data driven and evidence informed tool, to help systems make contentious decisions, enables traction and resolution where disagreement and inertia may otherwise prevail.
4. Using good, collective governance supports clear and mandated outputs and holds the system accountable to deliver system change.	The Joint Committee of Clinical Commissioning Groups was used to provide mandated approval for the outputs of the work.	A suitable, collective entity with authority and power must be identified for endorsement if development is to proceed to implementation.

Lancashire and South Cumbria used a number of tools in the first year of this programme of work and we share these in the hope that they are useful to others. We also share our reflections (which include the views of a number of stakeholders and colleagues) about the development of a new model of commissioning and the learning about translating theoretical models into practice.

The work to develop a new commissioning system in Lancashire and South Cumbria is on-going but a number of positive changes have been implemented so far, these include:

- **Eight commissioning agendas have all used the new Lancashire and South Cumbria commissioning framework to identify ways of delivering services more effectively through a place-based approach** (Children's services, Children & Young People's Emotional Wellbeing and Mental Health services, Urgent & Emergency Care, services to people with Learning Disabilities and Autism, Primary Care/Out of Hospital services, Individual Patient Activity including Continuing Healthcare, and Cancer services).
- **Adult Mental Health and Primary Care/Out of Hospital services are moving forward to test out implementation of the place-based approach,** being the first workstreams to progress development of their portfolio.
- **Standardised definitions have been adopted across the entire system to aid system wide working and avoid misunderstandings** (including definitions of commissioning functions, place, integrated care, local neighbourhoods and operating models).
- **A local People and OD Framework has been developed** (to support the system to align talent and capability to new ways of working and to support organisational culture change).
- **Providers, commissioners, Local Authorities, clinicians and practitioners have been engaged** (in the co-production of the Frame work and the plans to implement changes in the eight commissioning agendas).

In Summer 2018, representatives from NHS England kindly undertook semi structured interviews with key participants in the commissioning development process to gain feedback on the approach taken and the outputs achieved. The outcomes from those interviews have informed our 'tips for others' in the sections below.

Contents:

1. Introduction

Introduction

Healthier Lancashire and South Cumbria is one of the first shadow Integrated Care Systems in England. It is a partnership of organisations working together to improve services and help the 1.7 million people in Lancashire and South Cumbria live longer, healthier lives.

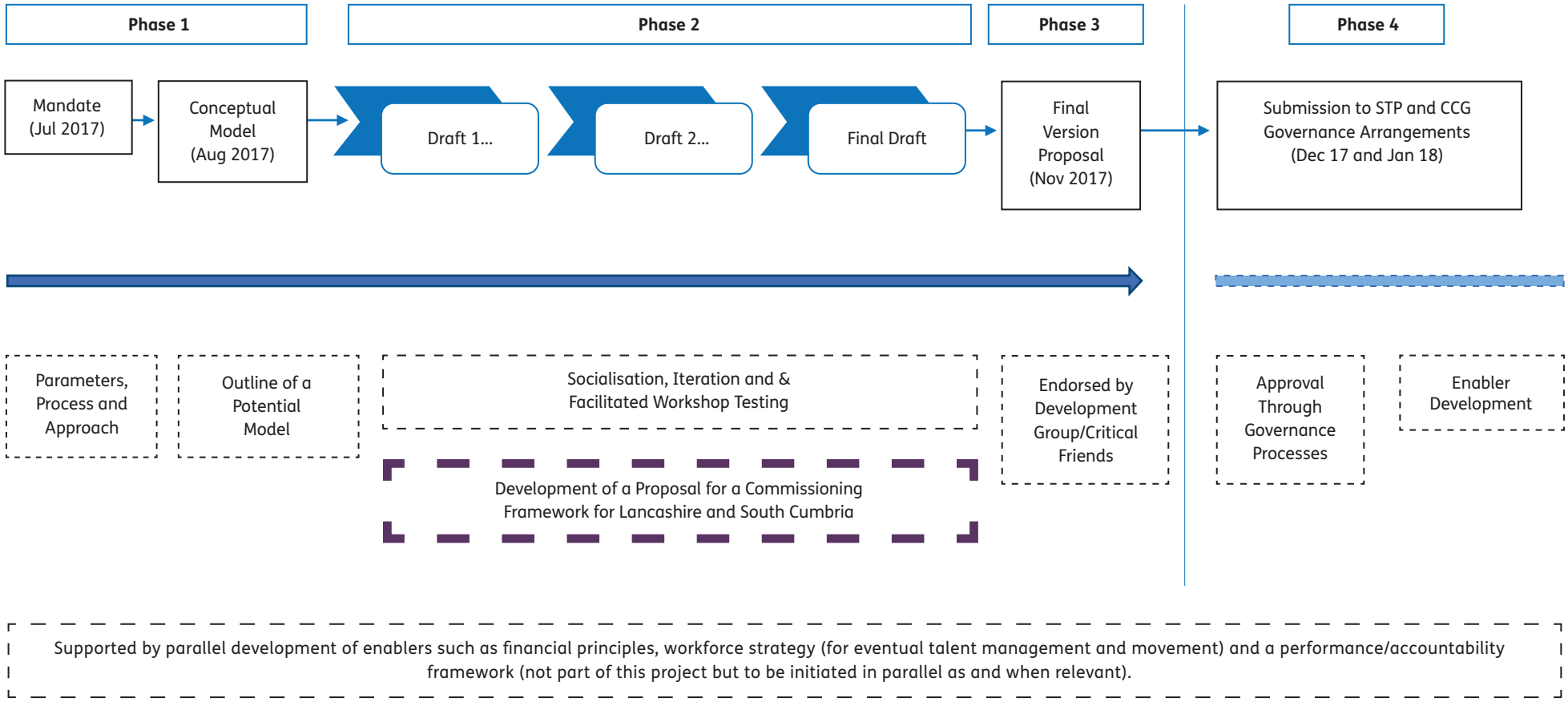
The partnership is made up of NHS, Local Authority, Public Sector and voluntary and community organisations coming together to improve services, reduce pressures and make best use of our financial resources. To achieve it's goals, Healthier Lancashire and South Cumbria have embarked on a change programme to deliver place based commissioning as a means of improving care and outcomes for local people. This article describes that journey, focusing on the lessons learnt in the first year of what will ultimately be a long-term plan for change.

In the Spring of 2017, the eight Lancashire and South Cumbria CCGs began to consider a new model of commissioning for what was then the Lancashire and South Cumbria Sustainability and Transformation Plan (STP) footprint. The CCGs embarked on a journey to design a new system, alongside providers, local authorities and primary care. The work was branded 'commissioning development'. The intention from the start was very clear: identify a better way of working together that drives improved outcomes for patients, enables system efficiencies and supports reduced running cost requirements, both at scale and more locally. The work was approached in four phases.

In January 2018, the outputs from a 6-month programme of work were endorsed by the Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups (JCCCG). Following that a mobilisation plan was developed and work is now underway on the implementation of a Commissioning Framework for Lancashire and South Cumbria.

The results of the work and the lessons from the approach taken are shared here. An overview of the process is described below along with feedback from stakeholders who were interviewed to gain their views on the experience of being involved in the work so far. We have summarised the learning from our journey to date into some key principles.

The reader will see references to language used throughout the project to describe systems e.g. STP, LDP, ACS, ICS and ICP etc. This is not intended to confuse the reader! As the project progressed national language changed rapidly and various new names were introduced for systems. The project faithfully refers to language used at the relevant point in time.


Phase 1
Phase 2
Phase 3
Phase 4
Mandate (Jul 2017)
Conceptual Model (Aug 2017)
Draft 1...
Draft 2...
Final Draft
Final Version Proposal (Nov 2017)
Submission to STP and CCG Governance Arrangements (Dec 17 and Jan 18)
Parameters, Process and Approach
Outline of a Potential Model
Socialisation, Iteration and & Facilitated Workshop Testing
Development of a Proposal for a Commissioning Framework for Lancashire and South Cumbria
Endorsed by Development Group/Critical Friends
Approval Through Governance Processes
Enabler Development
Supported by parallel development of enablers such as financial principles, workforce strategy (for eventual talent management and movement) and a performance/accountability framework (not part of this project but to be initiated in parallel as and when relevant).

2. Lancashire and South Cumbria

Lancashire and South Cumbria

Healthier Lancashire and South Cumbria is a partnership of organisations coming together to improve outcomes and care for local people, reduce pressures on services and make best use of financial resources. The region covered by Lancashire and South Cumbria is diverse and the configuration of organisations is complex (as demonstrated by the list of constituent organisations below). The geographies are different and so are some of the local challenges. There are five local areas within the Lancashire and South Cumbria STP footprint.

Bay Health and Care Partners

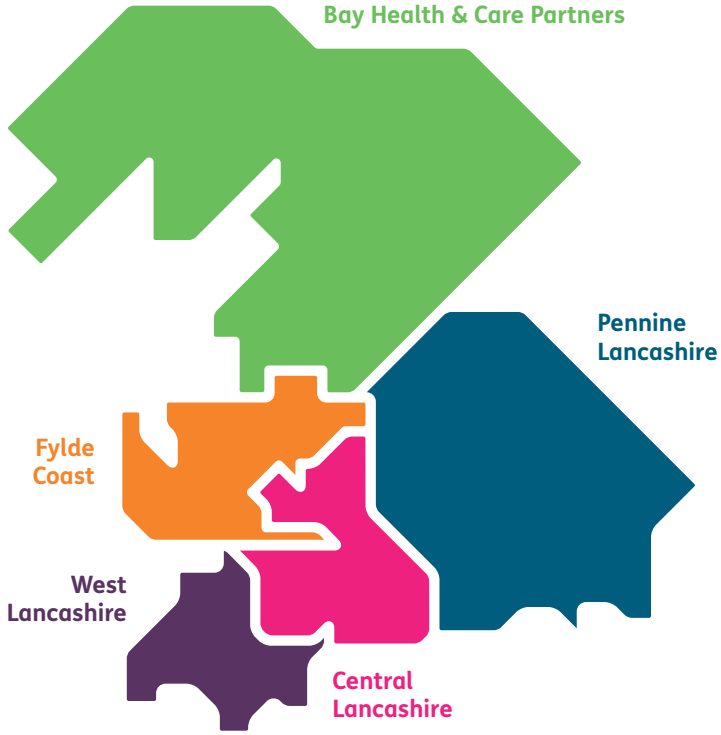
- NHS Morecambe Bay Clinical Commissioning Group
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Cumbria Partnership NHS Foundation Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- South Cumbria GP Federation
- North Lancashire GP Federation
- Cumbria County Council

Central Lancashire

- NHS Greater Preston Clinical Commissioning Group
- NHS Chorley and South Ribble Clinical Commissioning Group
- Lancashire Teaching Hospitals NHS Foundation Trust
- Preston City Council
- Chorley Council
- South Ribble Borough Council

West Lancashire

- Southport & Ormskirk Hospital NHS Trust
- NHS West Lancashire Clinical Commissioning Group
- West Lancashire Borough Council



Fylde Coast

- NHS Blackpool Clinical Commissioning Group
- NHS Fylde & Wyre Clinical Commissioning Group
- Blackpool Teaching Hospitals NHS Foundation Trust
- Blackpool Council
- Fylde Borough Council
- Wyre Council

Pennine Lancashire

- NHS Blackburn with Darwen Clinical Commissioning Group
- Blackburn with Darwen Council
- NHS East Lancashire Clinical Commissioning Group
- East Lancashire Hospitals NHS Trust

Other Organisations working Across the Region

- Lancashire County Council
- Lancashire Care NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- NHS England
- North West Ambulance Service NHS Trust
- A wide range of voluntary, community and religious groups

Key Facts about Lancashire and South Cumbria

- Population of 1.7 million
- The budget for all the partner organisations combined is £3.1 billion a year for health and social care in Lancashire and South Cumbria
- The system as a whole faces 6 major challenges:
- Fylde Borough Council
- Wyre Council
    - Financial shortfalls due to increased demand for services
    - Poor health throughout our region
    - Lack of joined-up care
    - An ageing population with complex needs
    - Problems recruiting and retaining staff
    - Increased need for mental-health support
- The Lancashire and South Cumbria STP is clinically led by Dr Amanda Doyle with support from senior clinicians, health professionals and managers from every part of Lancashire and South Cumbria
- The system is overseen by the JCCCG which makes legally binding commissioning decisions delegated by CCGs and provides scrutiny and assurance of consultation processes.
- An integrated Care System Board provides leadership and development of strategy, transformation and design of future state

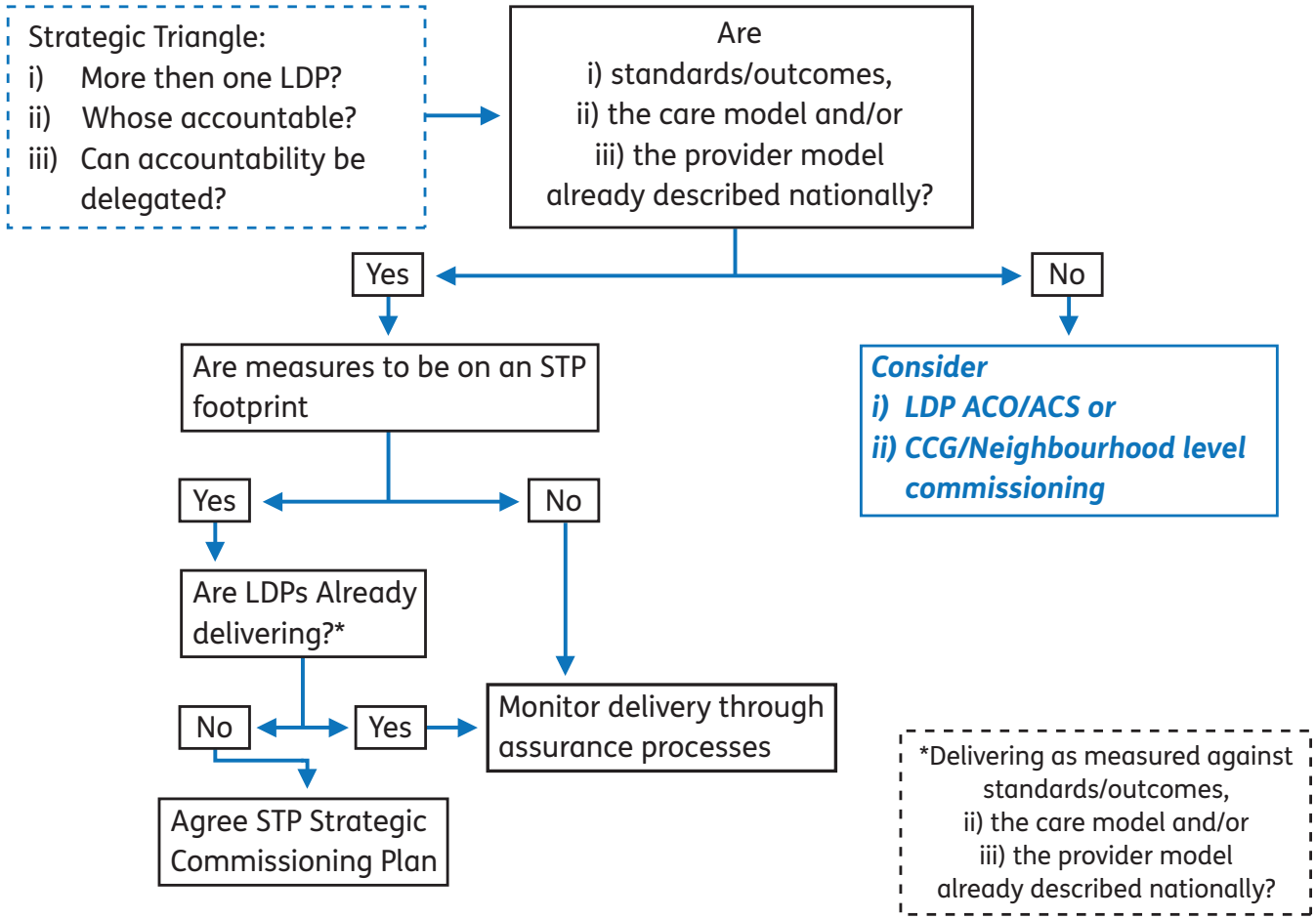
3. **Phase 1:** Mandate and Methodology

Phase 1: Mandate and Methodology

Work on designing a new commissioning system for Lancashire and South Cumbia got underway in July 2017. It initially focused on taking the first steps towards the development of an 'at scale' Strategic Commissioning Function. The decision to develop a Strategic Commissioning Function was based on a pragmatic view at the time. Lancashire and South Cumbria had duplicated commissioning functions delivering varied outcomes and running cost challenges to achieve. The opportunity to consolidate some things into a footprint wide strategic commissioning function and to at least streamline priority commissioning activity seemed like a sensible starting point; a sort of one step at a time approach.

A conceptual model describing the functions that could be 'elevated' from local systems to a bigger, single STP footprint Lancashire and South Cumbria Strategic Commissioning function was developed by Julie Haywood Consulting Ltd, in partnership with a small group of CCG leaders. The conceptual model proposed a high-level approach with a definition, scope, governance and enablers.

A rationale for moving things to 'scale', together with expectations for high level benefits (reducing operational pressures in commissioning organisations, increasing standardisation of approach, aiming to reduce variations in outcomes, sharing skills and capabilities more widely and more evenly, a single lens on performance across the footprint) was included within the conceptual model. The model also included an algorithm to help make decisions about activities that should be shifted to a strategic commissioning function. The model was presented to a small workshop of senior CCG leaders.


Strategic Triangle:
i) More then one LDP?
ii) Whose accountable?
iii) Can accountability be delegated?
Are
i) standards/outcomes,
ii) the care model and/or
iii) the provider model
already described nationally?
Yes
No
Are measures to be on an STP footprint
Consider
i) LDP ACO/ACS or
ii) CCG/Neighbourhood level commissioning
Yes
No
Are LDPs Already delivering?*
No
Yes
Monitor delivery through assurance processes
Agree STP Strategic Commissioning Plan
*Delivering as measured against standards/outcomes,
ii) the care model and/or
iii) the provider model
already described nationally?

The workshop was set up to be interactive. A table was laid out with leaders standing and being asked to offer a logistical, birds eye view of the system. At the workshop leaders were asked to physically move blocks around a table; each block representing a commissioning function and parts of the table representing a place in the system (local CCG, local development area/multiple CCGs or single strategic STP). Leaders were asked to move those functions that they thought could be done better at the STP footprint/Strategic Commissioning Function only (at that stage), using the conceptual model as the backbone for propositions. They were asked to explain their rationale for any suggested shift.

Three things quickly became evident in the session:

i) An individual leaders rationale for a move of function was understandably borne out of their own experience. Leaders who were committed to moving a particular function from diverse local arrangements to a single STP approach saw the benefits of consistency and uniformity. Leaders who rallied against it saw the threats to local innovation, local community focus and local and legal governance and control. Blocks moved in and out of spaces many times!

ii) Leaders put forward evidence to support why a function should shift based on their own knowledge and expertise in a particular area of business. Failure to achieve targets or key performance indicators within a particular commissioning agenda was a strong driver behind believing that a shift was required.

iii) Any movement of anything to the 'at scale' space created a consequence for local CCG and multi CCG responsibilities. Questions like 'if you do that there how will we do this here?' resonated throughout the discussions.

The workshop concluded with reflections:

- Why did we think moving functions to an STP footprint would deliver better outcomes compared to a local approach and what was really 'evidence'?
- How could we develop an 'at scale' commissioning offer without considering what this meant for the local part(s) of the system?
- What approach could we use to make decisions with such diverse and passionate views?

To some extent the reflections helpfully took us back to the drawing board. An approach to making decisions, based on a shared view of the 'right thing to do' for the whole system, was required. We began to understand this as 'system choreography' - noting that there was no single (national) musical script and there were multiple dancers all with varying dancing styles. There were people and organisations wanting to rhumba with partners who greatly preferred a tango!

In August 2017 an expanded group of CCG and STP leaders was brought together with an informed, respected and authoritative facilitator (Mike Farrar Consultant). The group were pushed to embrace whole system change rather than adopt a piecemeal approach. An imperative for whole system reform was established.

The group were reassured by updates provided on national thinking that shifting to focusing on the design of a whole system based on place-based commissioning, integrated organisations, aligned action, devolved responsibility and aggregated management would be supported by what was understood at the time as national expectation.

Following the session, the scope of work for commissioning development was extended. CCG leaders had acknowledged that it hadn't been helpful to try and change a complex and interdependent system one part at a time. A new scope of work was extended to the below:

- Define a truly place based approach with a clear understanding of what function should be undertaken in which place.
- Define the STP level, collective commissioning function (with a pipeline for implementation, a process for early adoption where appropriate and a plan for future development over time).
- Define the ACS/LDP level commissioning function (with a clear set of statements about the process to shift from CCGs to ACSs and the safeguards that will be in place to ensure good governance and clear accountability).
- Define how we will work with partners (CSU, NHSE/I, Local Authorities, Primary Care and others) to transact changes.

This new scope of work and the new found clarity of purpose and mandate was a significant milestone in the design and initiation of the overall programme. Leaders had been enabled to develop collective confidence and shared ambition which allowed for consensus and gave decisive permission to proceed.

A broad timeline (6 months) for designing the new system was outlined and a programme of work was commissioned with Julie Haywood Consulting. The sense of a 3-year programme of change began to emerge. The development of a Strategic Commissioning Function was now to be re-defined and undertaken as part of the development of the whole commissioning (and provider) system.

A new approach to developing the commissioning system was designed during August 2017 with a much clearer focus on the co-production of a whole system model. Rather than an isolated conceptual model and decisions implemented by small group of leads, the Lancashire and South Cumbria system opted for something much more inclusive and more organic.

A Task and Finish Leadership Group (named the Commissioning Development Group or CDG) was established with a group of selected CCG leaders who had influence, experience and who represented Lancashire and Cumbria from across the footprint. At initiation the Group agreed to meet every 2 weeks. The CDG was supplemented with a colleague from Specialised Commissioning North West. Most importantly the Group had complimentary personal and professional skills that could be leveraged. The CDG would eventually become a significant asset in the change management process.

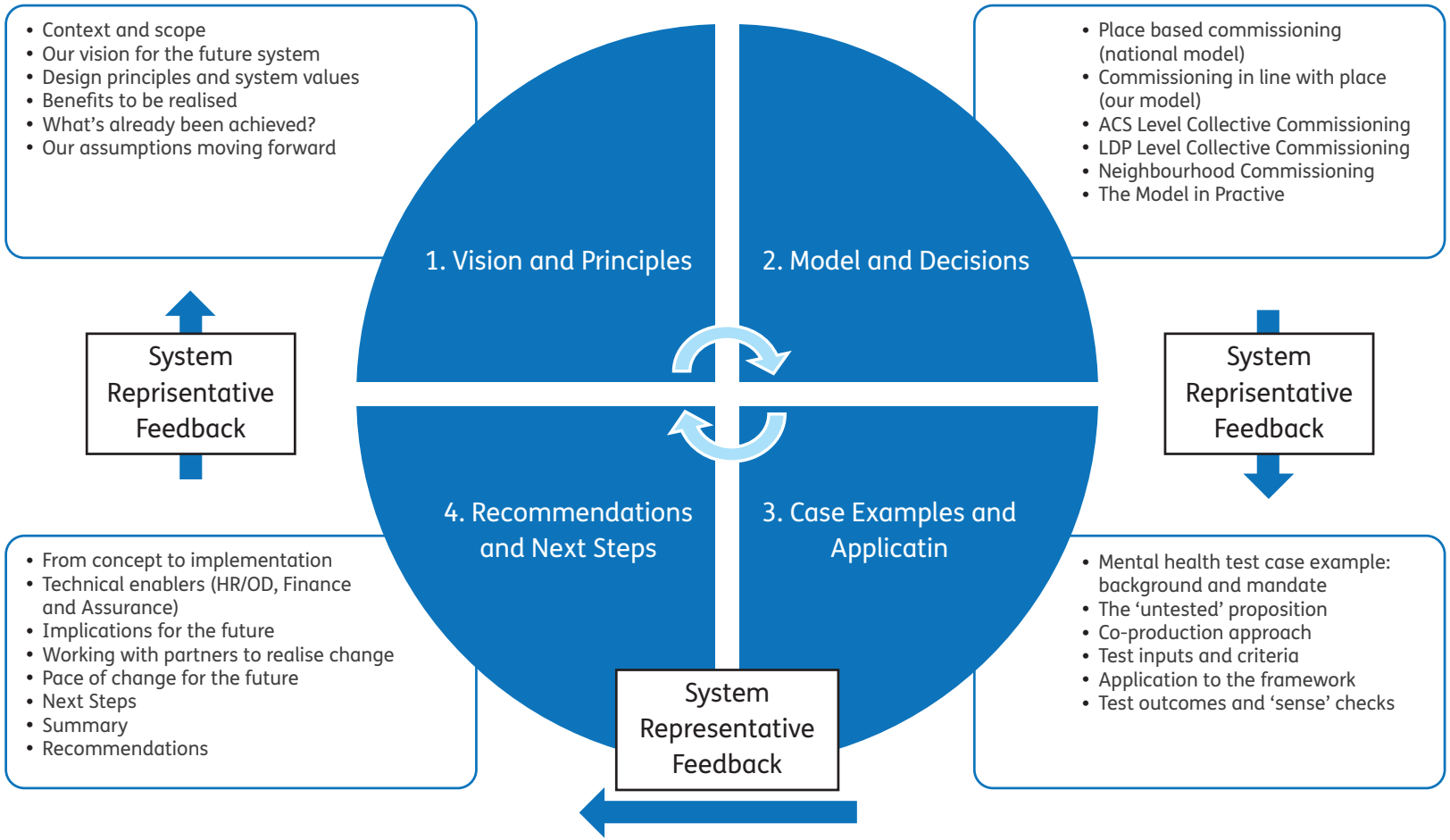
The Group was explicitly mandated by the STP lead who firmly and clearly expressed support for the work and the emerging approach. The STP lead was a vital 'check and challenge' resource in the Group, informed by emerging thinking nationally as well as local organisational leadership and clinical practice. The CDG was headed up by a leader who was known to be very skilled at collaboration in complex systems.

Additional external capacity was mobilised (and committed) to objectively support the CDG with the actions and tasks of what was by now clearly seen as a significant programme of work. Lines of communication (both up and out) as well as reporting were established for the Group.

A little bit of time was taken to allow the CDG to form a bond around the new programme of work at hand. The first two meetings of the group were given over to understanding the scope of work and each other's skill sets. Links were established between the Group and other areas embarking on similar work as well as national leads at NHS England.

An outline approach to designing what was by then re-branded from a Strategic Commissioning Function to a Lancashire and South Cumbria Commissioning Framework was co-developed by the CDG. The design approach is outlined below.

Development of A Proposal for a Commissioning Framework for Lancashire and South Cumbria: Process to Follow



At step 1 in the approach described above the CDG went 'back to basics'. Fundamentals such as principles for change, the case for action, the vision for the future, benefits to be realised for individuals, communities, staff and organisations and the governance and delivery expectations were agreed and proposed by the Group. Language was set to enable a consistent understanding. A Glossary of Definitions was used by CDG and included in step 1 content to avoid misinterpretation and help focus the system around a shared set of meanings: 'when we say x we mean y'. This proved important at various points in the work.

The Group endorsed the following vision:

*"In 3 years' time we expect to have a fully functioning **Lancashire and South Cumbria Health and Care "Board"** which receives an allocation of statutory* funding in order to commission integrated health and care services to promote and enable improved health and well-being for the whole population. The financial allocation may be constituted from both national and local government sources.*

*The "Board" will work closely with a **Group of maturing, local Accountable Care Organisations (or other local systems)** to commission long term improvements in service standards and population health outcomes. The ACOs etc will work effectively with clinical leaders and a range of local partners including district councils, general practices, third sector organisations and local communities themselves to agree health and wellbeing priorities at a neighbourhood level".*

A draft document of content including the proposed approach to developing the Framework (above) and draft content for Step 1 (vision, expected benefits in the new system and proposed governance of the work) was put together in slide deck format and circulated with a very clear, explanatory supporting letter signed by the STP lead and the Chair of the CDG. The key at this stage was the authenticity behind the request for comments. The CDG had proposed something that it felt could work. However, the Group genuinely wanted and needed a sense of resonance (or not) from the wider system.

Stakeholders from across the system were identified (Chairs and Chiefs, lay members, Exec Teams, passionate or influential system commentators) and invited to receive the draft approach and draft vision, expected benefits from the new system and proposed governance of the work. Stakeholders were invited to provide comments even on this early phase of the work.

All comments were catalogued and assessed one by one by the Task and Finish Group. Criteria for changes were agreed (i.e. material and content amended, not material now but noted for future phases of the work, no change required) and all comments were addressed formally with responses from the Task and Finish Group recorded. Reporting and communication channels were used to let people know what had changed in the approach, vision, expected benefits and proposed governance, in response to comments. This approach to consultation was followed throughout the programme of work.

Interviews with a small sample of stakeholders revealed that the efforts made to get the overall approach and the fundamentals at step 1 right were to be invaluable to the rest of the work. Feedback from interviewees is highlighted below.

Phase 1: Gaining buy-in to the initial proposition

The following learning and reflections were made:

- There was a clear narrative for the case for change – both locally and at the national level. The programme built on the wider change happening in the NHS with relation to commissioning and integration.
- The mandate for change and to start the process came from the STP leader – this was seen as an important foundation.
- The initial work provided a vision for what the system was trying to achieve.
- The system leadership was careful not to define local part nerships or relationships because these were for local areas to determine.

Tips for others

Be clear about how changes to commissioning arrangements will lead to improvements to services and for patients. For example, the changes should lead to reduced duplication, standardisation, greater efficiencies for providers and potentially reinvestment of cost savings. Commissioning is an enabler for change, not an end in itself.

Provide a dedicated group of individuals with resposibilty for delivery of the programme.

Ensure you appoint a local leader that is able to articulate the vision and who is respected by the local community and local commissioners. The leader should be orientaed to collaborative work and able to sythesise differing opinions and work. You need to trust that person to work on your behalf fairly and equally. This person should also have experience with change management.

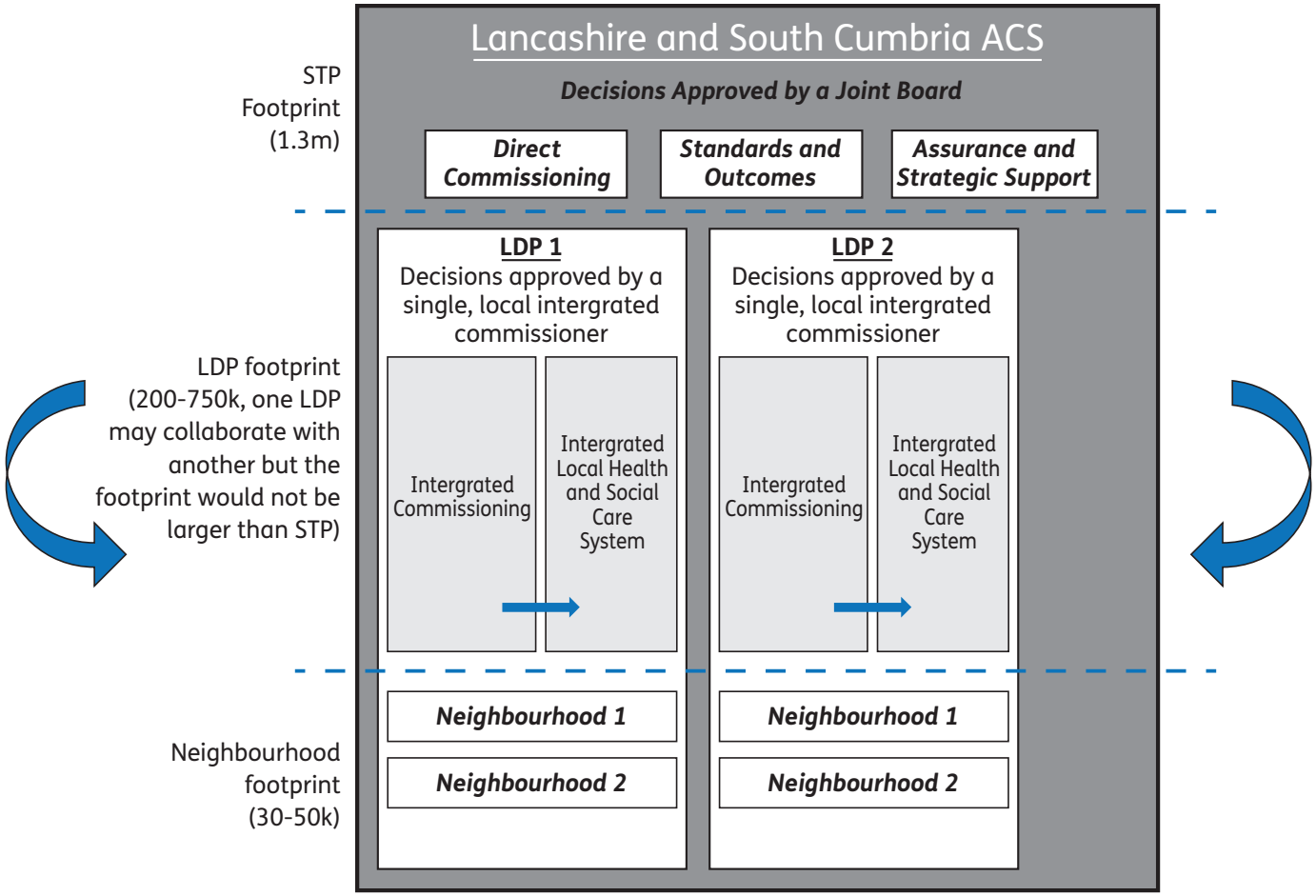
Avoid going down the transactional route. Get people to think about organising their work in a different way. ‘We want to achieve this with cancer so how do we organise the work around this? If you are responsible for delivering X, how would you deliver it?’ rather than jumping into specifics of how things should be organised.

Do not wait until you have all the processes and structures in place. There is never a perfect place to start and some pragmatism is needed. Also, do not wait until you have complete consensus. Outline a broad framework and then see where things go.

4. Phases 2 and 3: Design and Development

Phase 2 and 3: Design and Development

Integral to the development of the Commissioning Framework was the fundamental commitment to shift the Lancashire and South Cumbria system to place-based commissioning ('the right care, in the right place, at the right time'). At step 2 of the approach to design the CDG endeavoured to understand a locally relevant application of place-based commissioning. The Group worked with NHS England and others to define a theoretical model for future commissioning; one based on three key layers or 'places' (neighbourhoods, integrated care partnerships and the STP/ICS). Technical factors such as population scale and commissioning functions were proposed for each 'layer'. Our model is provided below.



The model was developed as an aid not a prescription. It was based on a shared (local and national) view that evidence would drive a shift of activity and delivery to the right place for the right reasons.

No one place (or layer) was considered as more important than any other in the system (and for this reason, **and based on learning in other areas too,** the concept of 'strategic commissioning' happening at the STP level only was dropped). Instead the idea of a shared set of functions operating at specific 'places' to the benefit of individuals, communities, staff and organisations was promoted. Freedom to decide as a system what the right place was for any particular function was also promoted (though rigour and discipline around evidence and decisions were to be applied to all propositions made for commissioning activity to shift its existing arrangements to new ones. More on this is described in Phase 3).

Establishing a shared understanding of 'place' (geography, population, description and interconnections) was fundamental to reassuring the system that there was no hidden 'one size fits all' intentions in the Lancashire and South Cumbria ambition. Place has to be locally relevant and demographically meaningful for stakeholders and leaders to buy into the definition. It cannot be territorial. It must make sense in terms of the delivery of care and access to services.

The CDG committed to a series of co-production/engagement workshops (with leaders and with local managers, practitioners and clinicians) to test the model. The benefits of engagement were clearly felt as positive inputs were gained and used to further refine assumptions and understanding.

Interviews with a small sample of stakeholders revealed that the efforts made to get the model at step 2 of the design approach right were to be crucial to the rest of the work. Feedback from interviewees is highlighted below.

Using co-production to develop a model

The following learning and reflections were made:

- Engagement with the local experts has been a founding principle of the work. Leadership has been there to set the agenda and overall vision but local experts were called on to define the detailed parts/next steps/implementation.
- Materials were developed for the workshops that allowed everyone to contribute equally (from explanatory materials to the voting buttons which allowed for equal participation).
- Achieving a successful programme is the result of individuals' drive and ability to 'sell' the programme.
- The CSU has been a key part in driving this agenda forward.
- They have provided support and leadership in thinking through the varying commissioning processes/functions and with data analysis.

Tips for others

Ensure that leadership is able to build bridges across providers/commissioners/other stakeholders. Consider including an independent figure who can hold others to account with more impartiality.

Do not underestimate the benefits that will be gained by taking the time to engage with a wide set of stakeholders and show them that they are part of the journey.

Demonstrate to those engaged how their involvement is supporting and influencing the development of the programme. Ensure that everyone is clear abouut the process, why they are there and what they are expected to contribute. Prepare materials and have a clear agenda.

Allow working groups to adapt and further develop the vision to suit their local need or their particular service area. This is particularly important for the neighbourhood level which in itself, is defined differently in different areas.

Ensure that a least some of the people who attend any meetings/workshops are those who are able to make decisions and also socialise plans within their own organisations. Ensure that you also have equal representation from the various inerested parties.

Do not assume that everyone understands the full commissioning process. In particular, explain how somethings could be done at an ICS level (e.g. contracting).

Do not start with the hardest thing first... make sure the initial goals/ambitions are achievable.

Consider how to build confidence in the process over time.

In order to support the workshops with testing the model an approach to understanding how to answer, 'what right place for which right function?' was needed. It was agreed to test the approach with one commissioning agenda and mental health was selected for this purpose.

The mental health commissioners developed a process for aligning the mental health commissioning agenda to the three places (STP, ICP or Neighbourhood) identified in the model. They adopted the following steps:

i) Break down the agenda into all the services commissioned (so for mental health this included service areas such as In-Patient Care, Eating Disorder Services, Early Intervention in Psychosis Teams, Dementia Services, community projects and so on).
ii) Categorise commissioning activity into the places (layers) proposed in the new model using informed opinion, experience and knowledge (e.g. In-Patient Care at the STP level but community projects at neighbourhood level).
iii) Test proposed place-based categorisation with collective discussion between a broad spectrum of stakeholders relevant to the commissioning agenda.
iv) Where agreement is not evident use a data driven decision-making criteria and decision-making tool (developed by Kate Turner Consultant) to help apply evidence in a collaborative and yet objective way.

An adapted decision-making criteria and tool were used to test application of parts of the mental health agenda to the place-based commissioning model by consideration of 31 questions across 5 domains.

Domains looked at data driven evidence around known patient numbers, demographic factors, strategy, provision, financial risk. Questions broke domains down into a more detailed analysis (e.g. what is the prevalence, are there different requirements driven by different demography in different parts of the patch, is there unacceptable variation in usage or outcomes, does the service require highly specialised knowledge or links between centres, are high cost drugs or devices part of this service?).

Answers were categorised according to a pre-defined 'pick list' of options. On completion the criteria and the tool provided a numerical indicative output (a 'score') that was used to understand whether the service was best commissioned locally or at scale. The tool was sensitive to variation across the domains (e.g. where one domain may produce a clear preference while the other an opposite one).

Throughout September to November 2017 the mental health commissioners used a series of engagement exercises to apply steps i-iv of the process above. Clinicians, commissioners, local authority partners and provider representatives were all involved in a 12-week process which included the following:

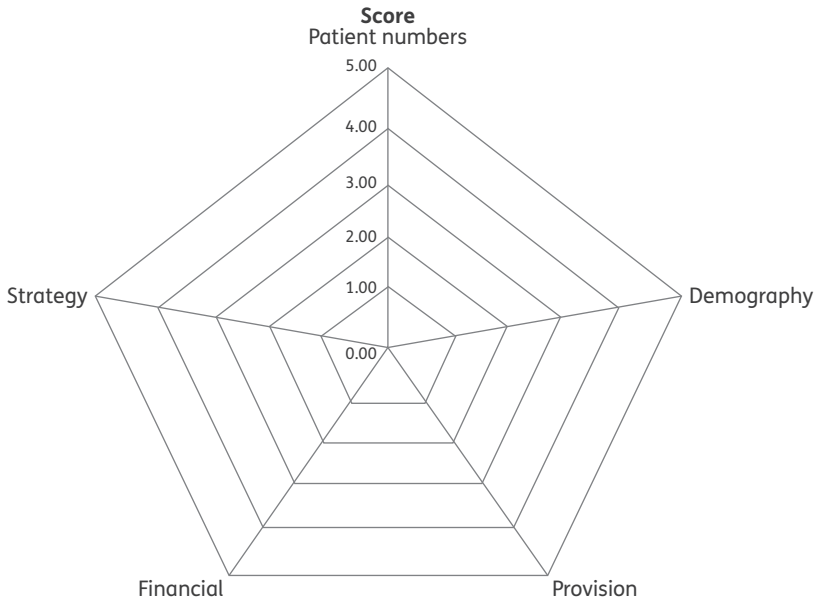
- Understanding the commissioning model.
- Identifying and agreeing the services and functions that comprise the mental health commissioning agenda (e.g. eating disorder services, in-patient care, dementia diagnostics etc.)
- Testing and re-testing the mental health commissioning agenda against the model using the decision-making criteria and specifically the scoring tool where consensus could not be reached.
- Reviewing outputs and sense checking decisions and place-based recommendations.

The decision-making criteria and tool were applied by consultation with participants in the mental health engagement workshops to test place-based propositions about various service areas. Electronic voting buttons were used with the decision-making tool and participants were asked to individually score each of the decision-making criteria. Collated results from the scoring were shown to participants at the end of the session.

Results that showed high levels of agreement among stakeholders were accepted and agreed. Facilitated discussion was used where consensus was not evident through the tool and collective scores were agreed.

Collated outputs from the tool (and facilitated discussion) were plotted into spider diagrams. Points closer to the outside of the spider reflected a preference for STP level commissioning while points closer to the middle indicated commissioning being more locally led. Variation in the outputs enabled commissioners to recommend a blended approach (e.g. set standards and outcomes once but commission the service up to five times over in locally specific integrated delivery systems).

An example of an output from the mental health tests is provided opposite revealing a need for commissioning of psychological therapies at the STP layer of the system.



Example of a service assessed by the framework criteria:

This example shows;

That there is local scope for variation in how the service is provided and is potentially financially viable, however

This is outweighed by the Strategy (co-dependency with wider clinical pathways) Demography (numbers increasing), Provision (Workforce requirements) and therefor this would be commissioned once but could include local dialogue.

The total score using this framework would be 3, which applying guide below be **Once at STP**

The nearer the factors are to the centre out the output chart the smaller the population required for commissioning the service effectively.

As a guide:
0-1 = Located as close to peoples homes as possible, within each neighbourhood
1-2 = Within all LDP areas or more frequently
2-3 = Within settings which have serve greater population levels, for examples not necessarily in every LDP
3-4 = Once within the STP footprint
4-5 = May require travel outside the STP footprint

All the outputs from the mental health test case were ratified by the mental health stakeholders and written up into a Mental Health Commissioning Mobilisation Plan for approval by our governance group. The approach and outputs were also shared with wider stakeholders and the methodology was made accessible to a further six commissioning agendas; these included:

- Cancer
- Learning Disability
- Primary Care
- Urgent and Emergency Care
- Continuing Healthcare
- Children's

Further workshop sessions were held to assist the additional commissioning groups to work through the 12-week approach and the steps i-iv process as well as apply the decision-making criteria/the tool to their commissioning agenda if they needed to. Interviews with a small sample of stakeholders revealed that the efforts made to test the model at step 3 of the design approach were important to supporting the eventual implementation of the mode and supporting its progression. Feedback from interviewees is highlighted below.

Designing and using the decision-making tool

The following learning and reflections were made:

- The use of a data-driven, decision-making tool was extremely helpful to:
    - Introduce objectivity into the process and reduce the use of anecdotal evidence
    - Level out experience/opinions between participants
    - Inform participants with some basic figures/evidence on number of users, level of risk, level of speciality, etc.

Tips for others

Advance consideration of how you will deal with differences in opinion and power imbalances within participants is vital. A tool like this can be useful.

Using the tool for mediation purposes only ensures that the participants remain the drivers behind decisions made.

Piloting a tool with one service and then rolling it out to others can enable learning that can be shared and confidence in the process built.

The voting tool was another useful way of ensuring that everyone could contribute.

5. **Phase 4:** Outputs and Decisions

Phase 4: Outputs and Decisions

By January 2018 the CDG had completed the design and development process. The mental health test case was complete and made recommendations for shifting mental health commissioning activity to the new places (layers) in the system. The other six commissioning agendas were underway with their 12-week, step i-iv process to propose re-alignment. The model for a new commissioning system had been adapted iteratively based on feedback from the engagement workshops, the test case and consultation with leaders, clinicians, commissioners, local authority partners and provider representatives. The principles and aims of the model were widely supported, accompanied by the completed mental health test case and high-level recommendations for mobilisation and on-going development.

The model and mental health test case were submitted for approval to the programme's decision-making group (the Joint Committee of Clinical Commissioning Groups). The JCCCG had acted as the governance group throughout the programme of work, receiving updates and products endorsed by the CDG and an intermediary group (the Collaborative Commissioning Board made up of CCGs and Local Authorities). The JCCCG was a developing entity throughout this period of work having dedicated time through its initiation to understanding its constitution and role in the system.

Engaging the JCCCG in oversight of a commissioning reform programme empowered the JCCCG to take a direct role in a more transformative than transactional process.

Decision making at the JCCCG was pre-empted by much informal engagement and consultation with leaders and partners, primarily through the co-production approach described earlier. The JCCCG was objective and robust.

The JCCCG was important both in endorsing approval for the work but most importantly for acting legally on behalf of the system and endorsing the model at the end. In a complex and multi- system, one legally mandated group that can make decisions on behalf of the system is vital.

The model and test case were endorsed by the JCCCG with recommendations for next steps.

Interviews with a small sample of stakeholders suggested that the efforts made to engage the JCCCG as the governance group was useful. Feedback from interviewees is highlighted below.

Using good governance to support outputs

The following learning and reflections were made:

- The JCCCG had been developing/maturing throughout this process. The development of the commissioning framework and the request for the JCCCG to approve it bolstered the JCCCG role as a joint decision-making forum for important and collective system level commissioning decisions.
- Informal engagement with different CCG leaders by the leaders of the commissioning development work were helpful in ensuring that key individuals were kept up to date.

Tips for others

Ensuring that there is a collective place in which to sign off the plans – i.e. a joint committee is important. Those representing collective decision-makers should be sharing information in both directions (STP-ICP-Neighbourhood-ICP-STP).

Informal engagement is just as important as more formal mechanisms when it comes to governing change.

6. Progress and Next Steps

Progress and Next Steps

Since January 2018, drawing on the learning from the mental health test case, the six additional commissioning agendas have been increased to seven; all have involved colleagues from across the system who have worked with an extensive range of wider stakeholders to apply the place-based framework to the commissioning of:

- Children's services;
- Children & Young People's Emotional Wellbeing and Mental Health services
- Urgent & Emergency Care;
- Services to people with Learning Disabilities and Autism;
- Primary Care/Out of Hospital services;
- Individual Patient Activity including Continuing Healthcare; and
- Cancer services.

Continuing in the spirit of co-production, each of the seven workstreams has undertaken extensive engagement across CCGs and other commissioners, clinicians, providers, Local Authorities, the CSU and NHS England. Following engagement, the commissioning framework was updated to reflect the national changes in terminology which encourage the evolution of local integrated care partnerships (ICPs) and integrated care systems (ICS).

A standardised definition of commissioning and service transformation was also added to the commissioning framework to aid understanding and support the consistent use of terms (Continuing to define things so that there was a consistent use of terms may seem like design and development overkill! However, we constantly found potential trip ups arising with assumptions that a shared understanding was 'obvious, surely?'. Describing as much as possible in a standardised way assisted with momentum and gave confidence to the system that at some level we were beginning to understand the same dance music and agree the same dance routine).

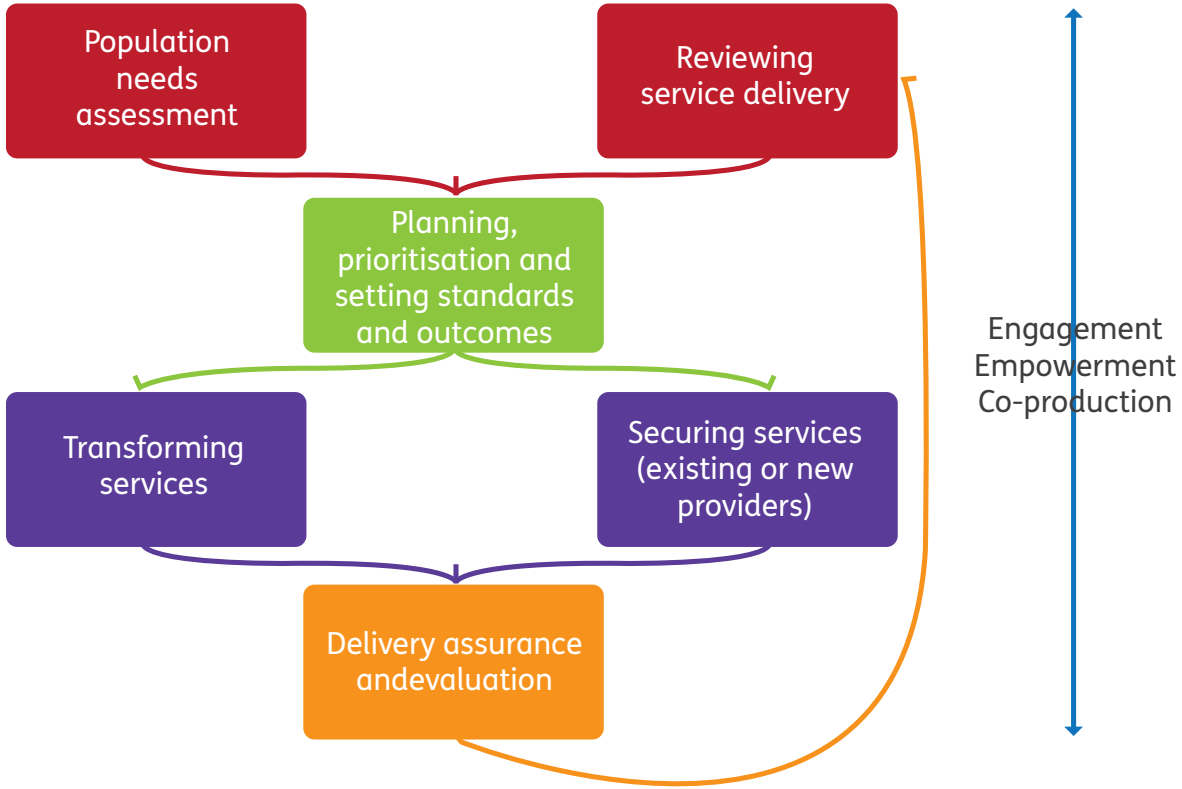
The latest set of definitions aimed to distinguish commissioning functions (arguably the transactional activities in the system) from the transformational activities to enable some further clarity and granularity around exactly what should potentially be happening where. A summary of our approach to these definitions is provided below.

Commissioning functions

- Identified six key functions (all or some elements of which will be undertaken at a ICS, ICP and/or Neighbourhood place):-

Transforming Services Activities

- New care and wellbeing models and partnerships
- New provision and governance models
- Self care and social prescribing
- Community empowerment
- Personal budgets
- New payment incentive and contracting approaches
- Enablers such as infrastructure, insight and workforce and leadership
- Innovation



Work was also completed on a more detailed and shared understanding of the Neighbourhood level of commissioning described in the framework, based on discussions with representatives from Fylde Coast, Pennine Lancashire, Central Lancashire and Morecambe Bay. A shared view on the definition of a neighbourhood, the role a neighbourhood will play in a local economy (and in relation to the rest of the system) and some of the benefits a neighbourhood can deliver has been defined and included in the revised framework document.

Reflecting the importance and value-add of the Neighbourhood level of commissioning was considered by system leaders to be key to the onward implementation of the commissioning framework. No one wanted to see any 'slipping' into mistakenly thinking of the new system as mostly centralised at the ICS level. Space for community-based developments, specific to local geography and local population, was always part of the thinking and strengthening that thinking within the framework was thought to give formal weight to what was always a clear intention.

Neighbourhood Characteristics

Core

- Focus on personalisation of care and and population health
- Responsibility for out of hospital care and wellness for registered population of typically 30,000-50,000 people
- Leads intergrated care team including health, social and voluntary care, typically of 100-150 people
- Builds social capital by empowering people and communities
- Has full knowledge of all care and wellness resource consumed by its population
- Has the ability to enter into risk and gain share arrangements to improve the effective use of resource
- Aims to provide economies of scale and collective resilience

Enabling

- Has a clear vision and delivery plan encapsulating commissioning and provision responsibilities
- Has robust and formalised leadership and governance arrangements, including conflict of interest management
- Leadership includes key out of hospital care and wellness partners
- Has strong working relationships with in hospital partners to develop intergrated care models and pathways
- Formalises intergrated care team leadership and operational arrangements
- Has complete interoperatability between care provider partners
- Receives dedicated transformation support from CCG/ICP staff
- Leverages business support from CCG/ICP and partner staff
- Has business intelligence support, including population risk segmentation
- Develops and delivers out of hospital care and wellness models
- Engages in ICP decision making
- Works with other neighbourhoods to deliver shared priorities

In addition to the evolution of the framework itself, there was also further enabling work on an underpinning Human Resources framework to ensure that commissioning staff are able to align their activities in a fair and transparent way. Two formal communication briefings were also released to keep staff up to date with the latest development work. A formal mobilisation plan was also created by the Commissioning Development Group.

In June 2018, the JCCCG received a paper providing an update on the development and implementation of the framework since January together with, for each workstream, a set of recommended commissioning priorities for each place. The paper also indicated an intention to apply the framework to planned care services and to progress work around integration/alignment of commissioning activities with Local Authorities.

The JCCCG agreed the recommendations and asked that work to develop operating and support models be progressed.

Following the JCCCG decision in June 2018 it was agreed to further formalise the governance and delivery arrangements that had to date underpinned the development of the framework. The Commissioning Oversight Group (COG) was established to:

- Further choreograph the implementation of the recommen dations of the working groups for all the above services Define how collective commissioning resources across CCGs, CSU and NHSE would be applied and realigned across the ICS, ICPs and neighbourhoods in line with the agreed models
- Ensure that implementation plans are delivered in line with expectations
- Manage associated risks and issues
- Ensure anticipated benefits from proposed changes are achieved.

COG now meets monthly and is chaired by the ICS Executive Lead for Commissioning. It includes executive level representation from across the ICS, ICPs, NHSE and Commissioning Support Unit.

The COG has drafted a memorandum of understanding (MOU) between the partners within the ICS and ICPs which aims to outline how partner organisations will operate, behave and engage with each other to meet the needs of the system and ultimately the patients and service users whilst ensuring the commissioning system remains sustainable and that staff involved in the reconfiguration of the commissioning system are treated fairly, equitably and consistently. The MOU includes principles, behaviours and a proposed approach to the management of changes.

The COG has also progressed further work on the development of a People and Organisational Development (OD) Framework. The People and OD Framework is an evolving document which will be reviewed and will develop throughout the transition process. The Framework outlines the principles applying to the HR and employment processes supporting the alignment of functions, roles and new appointments associated with the development of the ICS and ICPs.

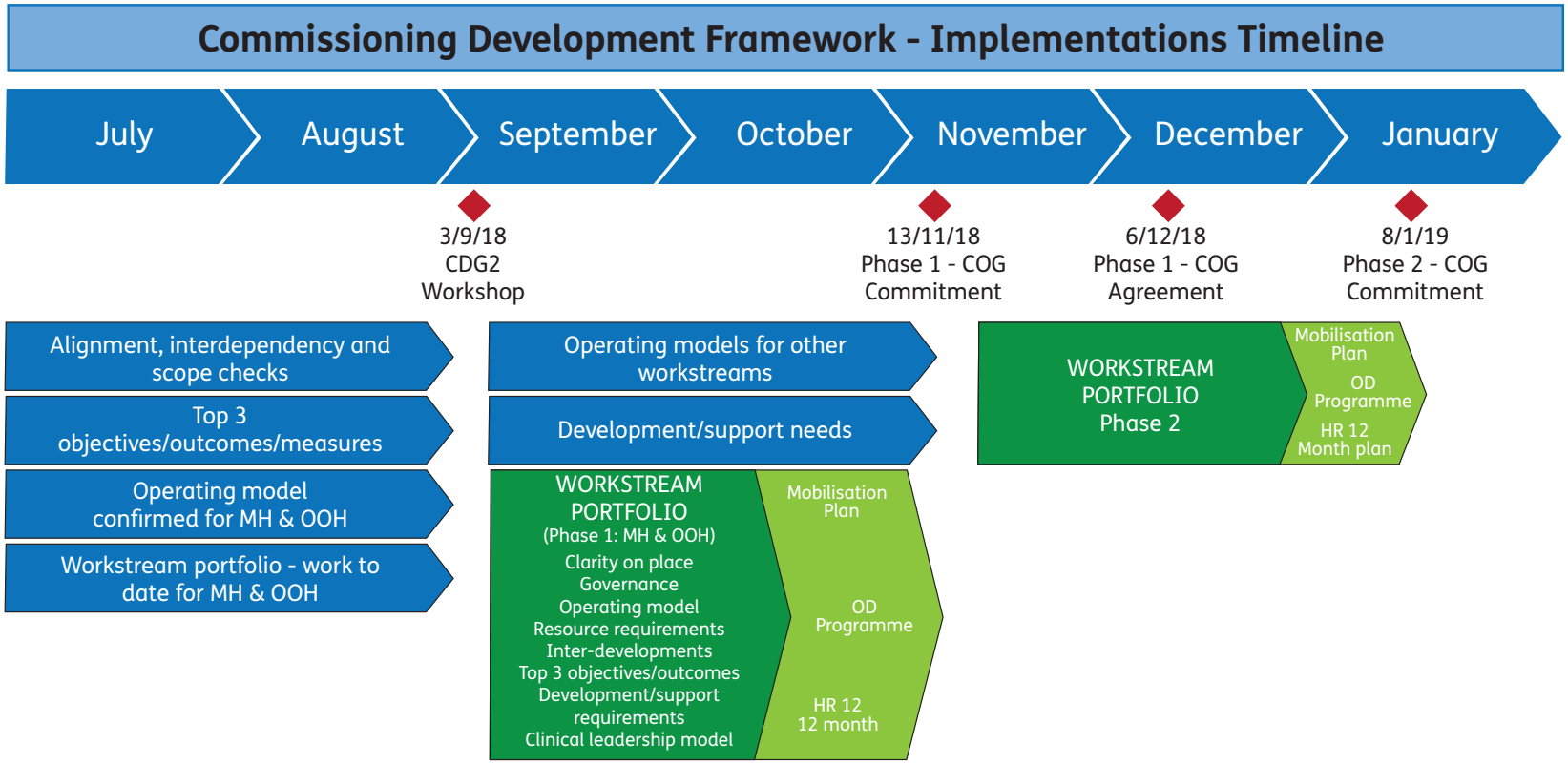
It also provides the guiding standards relating to any necessary employee movement from the current commissioning system to the new ICS and ICP arrangement and is intended to ensure consistency in the handling of employee matters going forward. The People and OD Framework recognises that whilst the new arrangements will require some new skills and competencies it is important that the system retains the wealth of experience, knowledge and skill that already exists, as we move forward. As such the role of OD is seen as central to the transition and further work is underway with workstreams to identify their OD requirements.

In order to ensure that workstream leads were fully engaged in and adequately supported throughout the work needed to implement the framework, it was agreed to expand the membership of the existing CDG to include the workstream leads and for that group to focus on bringing them together to:

- Share learning from the application of the framework to date
- Provide mutual support in ensuring all workstreams are ready to move through the implementation phase
- Develop and test out approaches to the next phase, adapting these to the requirements of the individual work streams as appropriate
- Resolve issues and tackle obstacles that may arise during implementation
- Drive forward effective implementation across all work streams
- Co-ordinate reporting of progress from the workstreams to COG and ultimately to JCCCG in December 2018

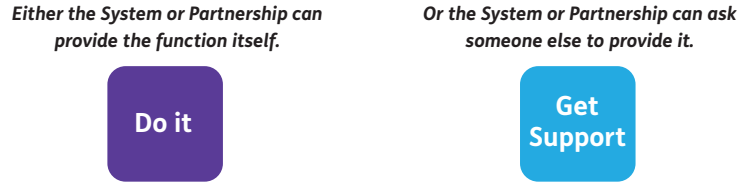
The group is chaired by the Executive Lead for Commissioning and meets as needed, often utilising a workshop format where leads share their approaches and the challenges that they are facing, working together to problem-solve.

To date, the expanded CDG has developed a timeline for the next phase of implementation together with a portfolio pack of information to be developed and presented to the JCCCG for agreement. The timeline, proposed portfolio content and phasing of workstreams have been agreed by COG.


Commissioning Development Framework - Implementations Timeline
July
August
September
October
November
December
January
3/9/18
CDG2
Workshop
13/11/18
Phase 1 - COG
Commitment
6/12/18
Phase 1 - COG
Agreement
8/1/19
Phase 2 - COG
Commitment
Alignment, interdependency and scope checks
Top 3 objectives/outcomes/measures
Operating model confirmed for MH & OOH
Workstream portfolio - work to date for MH & OOH
Operating models for other workstreams
Development/support needs
WORKSTREAM PORTFOLIO
(Phase 1: MH & OOH)
Clarity on place
Governance
Operating model
Resource requirements
Inter-developments
Top 3 objectives/outcomes
Development/support requirements
Clinical leadership model
Mobilisation Plan
OD Programme
HR 12 12 month
WORKSTREAM PORTFOLIO Phase 2
Mobilisation Plan
OD Programme
HR 12 Month plan

The CDG have collectively peer-reviewed their state of readiness to proceed with the next phase of implementation and agreed that Adult Mental Health and Primary Care/Out of Hospital will test out the approach, being the first workstreams to progress development of their portfolio for approval at the JCCCG in December 2017. The remaining workstreams will benefit from the learning from these two groups and will present their portfolios for approval at the JCCCG in February 2019.

The Out of Hospital Group have taken the lead on developing and testing out an approach for workstreams to use in developing recommended operating models. The group initially mapped out a range of potential operating models and through a process of discussion and iteration, proposed the simple question of "who does what (commissioning responsibility) and how is it best done (operating model)?". This is reflected in the diagram below:



The Out of Hospital Group then sought to apply this to the services in their workstream; seeking to answer the simple question of "who does what and how is it best done?" for each of the six elements of commissioning, for each service area. This was then followed by a process of checking alignment to ensure that what is proposed does not fragment working and/or create too many handoffs either vertically (service or bundle of services) or horizontally (commissioning function).

The next step was then to identify where the resultant operating model would require human resource changes and where it would require OD to support implementation.

The proposed operating model and changes have been shared with a wider group of stakeholders and supported.

The Out of Hospital Group have shared the learning from their work on developing and applying the approach through the CDG and it is now being rolled out through the other workstreams.

It is too soon to say how implementation is directly and/or indirectly benefitting the system and most importantly how we are improving patient care as a result. However, interviews with a small sample of stakeholders highlights the value of ensuring a focus on evaluating the early impacts (positive and negative) arising from the new commissioning approach.

Learning/reflections from participants

The following learning and reflections were made:

- The work to date has been around designing new commissioning processes and putting in place governance structures. The next step is around real implementation – this is crucial and has to done well.
- Once all the implementation plans are done, the leaders need to do a stocktake and understand how the plans and changes interact with one another. A check needs to be undertaken to ensure that the system has not inadvertently been fragmented further.
- Further work is needed to understand how cross-cutting services like cancer can fit into and with other work programmes.
- The STP programme team needs to further extend communications to those who have not been so heavily involved to date – e.g. all staff groups to check understanding, mobilisation and feedback.

Tips for others

Mobilisation is where the real wok starts but it can't happen successfully unless design and development has won hearts and minds so investment up front in co-production and engagement is essential.

The system needs to understand how it will know if anything has changed. (Like shifting from living together to being married in many ways everything and nothing changes overnight. The important thing is understanding what's better because of it).

The work to develop a new commissioning system in Lancashire and South Cumbria is on-going but a number of positive changes have been implemented so far, these include:

- **Eight commissioning agendas have all used the new Lancashire and South Cumbria commissioning framework to identify ways of delivering services more effectively through a place-based approach** (Children's services, Children & Young People's Emotional Wellbeing and Mental Health services, Urgent & Emergency Care, services to people with Learning Disabilities and Autism, Primary Care/Out of Hospital services, Individual Patient Activity including Continuing Healthcare, and Cancer services).
- **Adult Mental Health and Primary Care/Out of Hospital services are moving forward to test out implementation of the placebased approach,** being the first workstreams to progress development of their portfolio.
- **Standardised definitions have been adopted across the entire system to aid system wide working and avoid misunderstandings** (including definitions of commissioning functions, place, integrated care, local neighbourhoods and operating models).
- **A local People and OD Framework has been developed** (to support the system to align talent and capability to new ways of working and to support organisational culture change).
- **Providers, commissioners, Local Authorities, clinicians and practitioners have been engaged** (in the co-production of the Framework and the plans to implement changes in the eight commissioning agendas).

Conclusions

Principle	Experience	Learning
1. Gaining meaningful buy in to an initial proposition from those who will be key to success is absolutely critical.	The initial scope of work set a limited, incremental ambition that proved to be unhelpful in the pursuit of whole system change. It was reviewed to support a more whole system approach. The design of the approach was entrusted to a local leadership team, initiated to drive the work forward. They were credible, passionate and prepared to 'learn in action'.	Be clear about intentions right from the start and test the goals and expectations repeatedly with stakeholders and influential thinkers. Deploy the right leadership team with the talent and skills to focus on people primarily, supported by processes.
2. Using co-production to develop any new model or way of working yields the strongest commitment to make things work, despite uncertainty or challenges in implementation.	A commitment to engagement and iterative design was offered from the outset and was enacted through workshops and partnerships with local experts. The ability to propose ideas and test applications enabled the development of a model that felt relevant and feasible instead of purely theoretical or impossible to achieve.	Invest time, energy, resource and reputation in the co-production of a new way of working in a complex system. The sense of co-design and co-development fosters a problem solving will to do the right thing.
3. Designing and applying a bespoke, relevant and objective decision-making tool when decisions are contentious or critical adds science to art and enables progress when progress might otherwise get stuck.	Some decision-making criteria and a decision-making tool were adapted and applied to enable commissioners to test the model against real functions and responsibilities. The testing approach gave the model credibility and the outputs enabled recommendations for the model in practice that may otherwise have stalled.	A data driven and evidence informed tool, to help systems make contentious decisions, enables traction and resolution where disagreement and inertia may otherwise prevail.
4. Using good, collective governance supports clear and mandated outputs and holds the system accountable to deliver system change.	The Joint Committee of Clinical Commissioning Groups was used to provide mandated approval for the outputs of the work.	A suitable, collective entity with authority and power must be identified for endorsement if development is to proceed to implementation.

Acknowledgements

The Lancashire and South Cumbria commissioning system and Julie Haywood Consulting Ltd would like to acknowledge the following organisations/representatives for their invaluable support in sharing knowledge, tools and information that helped us in the course of our work:

- **Colleagues from the Greater Manchester System** (who offered us insights into the work around the development of a commissioning model in Greater Manchester and shared products and thinking with us. Conversations with colleagues from the Greater Manchester system helped us frame our initial thinking and gave us pointers at various points throughout our work).
- **NHS England Commissioning Policy Unit** (with particular thanks to Taryn Harding, Holly Holder and Johannes Wolff who provided a great deal of support in sharing conceptual models and policy context from national developments, undertaking interviews and research, facilitating learning sessions and providing critical reviews).
- **Local leaders, practitioners, managers and clinicians from across Lancashire and South Cumbria** (including at the STP level, within CCGs, the Councils, provider organisations, the commissioning support unit and primary care) for supporting the Commissioning Development Group, providing feedback, ensuring a high level of input and commitment, enabling a good governance approach for decisions and milestones, testing models and assumptions and supporting implementation.
- **Colleagues within the national Integrated Care System support programme and the Commissioning Connections Collaborative** who acted as critical friends and mentors in sharing developments and thinking from their own areas.
- **Kate Turner Consultant** for sharing the original decision-making tool and for supporting modification for application in this work.
- **Mike Farrar Consultant** (for providing expert facilitation to senior leaders).
- **Administrators from across the Lancashire and Cumbria system** (who provided essential logistical support through various engagement sessions).
- **Kings Fund** (whose various publications helped inform the must do's in our model).
- **Healthier Lancashire and South Cumbria Programme** (for support with documentation, communication and engagement and input to working groups).

We are grateful to everyone who gave us their open and honest views in workshops, interviews, meetings and groups. We appreciated all the feedback given on drafts and working versions which helped with finalising a model that was supported.

We were able to undertake this work with resource support from NHS England and dedicated capacity gained from external sources. Our experienced membership of the Commissioning Development Group, supported by our local STP leadership team, fully committed to the work and enabled us to successfully develop a model through a co-production approach.

Healthier Lancashire & South Cumbria

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