Devon Health and Social Care System Leadership Review – Report

FINAL VERSION

11th June 2019

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Contents

01

Forward

Forward

Placeholder for CCG / NHSE to contribute if required

02

Executive Summary

Executive summary, 1/3

The Devon health and care system has been subject to several reviews in recent years, beginning in 2016 with the Success Regime and CCG capacity and capability review; continuing with the Capped Expenditure Process; and, most recently in 2018, the Aspiring Integrated Care System (ICS) readiness programme.

This latest review of system leadership across the Devon Sustainability and Transformation Partnership (STP), was jointly commissioned by NHS England, The Devon STP Independent Chair, and the two previous CCGs in Devon that have now merged to form Devon CCG. Following a competitive tender process, PA Consulting were appointed to conduct the review, which was carried out during April and May 2019.

The review was commissioned in response to recent changes in STP and CCG leadership and the publication in the NHS Long Term Plan of the national policy goal of all STPs becoming ICSs by 2021. The original terms of reference for the review established three key lines of enquiry (KLoEs):

1. behaviours and ways of working that support the sustainable development of an integrated care system in Devon;
2. CCG leadership capacity and capability that supports effective commissioning across the Devon system; and
3. The right senior system leadership roles to support effective collaboration and partnership working.

To these three, PA advised adding a further two KLoEs, for wider context, which were later combined:

4. Building towards Devon becoming a fully-authorised and sustainable ICS; and
5. Defining the Devon health and care system at system-, place-, and locality-levels, and in relation to its external partners/ neighbouring systems.

The aims of the review are to provide:

- A level of assurance to NHSE/ I on the current position of the Devon system; and
- A constructive platform from which to become an ICS.

PA conducted over 40 interviews with Devon leaders; observed around 15 STP, CCG and local authority meetings; and reviewed many key documents. We also facilitated three workshops with CCG and system leaders. The PA review team deliberately adopted an independent and objective but also supportive and facilitative style, often described as a 'critical friend' approach. Full details of our approach are provided in the appendices to this report.

Executive summary, 2/3

The review process began as the 2019/20 Operating Plan process was due to be concluding. However, because the Devon STP was unable to submit a satisfactory STP Operating Plan, this process continued throughout the review period. Undoubtedly, this influenced the views and opinions of Devon leaders as they engaged with the review.

Six clear messages emerged from the review.

1. Devon has the potential to improve – as demonstrated under the Success Regime – but it sometimes struggles to hold onto the gains it makes.
2. The system leaders in Devon find it hard to have the challenging conversations with each other, necessary for fundamental transformation of the system.
3. Significant uncertainties/ ambiguities remain around the design of the future Devon system, particularly at locality-level; but also a strategic-level in relation to neighbouring Cornwall.
4. Inconsistent leadership – encompassing people, position and style at STP, CCG and wider system levels – has hampered Devon's ability to deliver sustainable improvements in finance and performance.
5. Devon struggles to attract external talent and ideas, which can lead to a lack of innovation or ambition; but Devon could do more to counteract this through a talent management programme and a research and evaluation function.
6. The role of CCGs as strategic commissioners and system leaders within a future ICS is still emerging at policy, strategy and operational levels; however, for now, Devon CCG has an important role to play in addressing the other five challenges.

Responding to the aims of the review, we conclude that Devon remains a challenged health and care system; but that it has the potential to turn around and become an ICS by 2021. System leadership, as much as any technical challenge, is at the heart of Devon's past challenges, but also its future potential.

How Devon leaders and their organisations engage in both the delivery of the 2019/20 Operating Plan and the creation of a Long Term Plan for Devon will be the key tests for long-term, self-sufficient success.

Devon CCG has already begun responding to the review, for example: by discussing the findings at a recent senior leadership team away day.

Executive summary, 3/3

In addition, we understand the new NHS England/ Improvement Regional Team are already taking steps to put in place additional system leadership, along with continued regulatory oversight and support for Devon, over the next six to twelve months. We think this is sensible and fits with the principle of 'earned autonomy' for STPs/ ICSs, as they mature.

Sections three, four, five and six of this report provide details of the individual finding of the review by KLoE. Section seven records the 'project charters' and delivery plans developed by Devon leaders during workshop 2. Finally, section eight provides further recommendations from PA.

03

KLoE 1
System Behaviours and Ways of Working

KLoE 1 Key Findings

The Devon system needs to develop the right behaviours and ways of working to drive system transformation

1.1 System working has not maintained progress following the success regime

1.2 Avoiding conflict is getting in the way of addressing key challenges

1.3 There is inconsistency in words and actions from leaders

1.4 Leaders meet frequently but relationships could be better developed

1.5.1 The governance structure is right but it needs to work better

1.5.2 PDEG does not drive system transformation

1.6 There is a lack of ownership and solution-focus to address challenges

1.7 There is a lack of coming together to work as a system

1.8 There is followership but not enough to achieve system outcomes

1.9 A greater level of system leadership skills are required to enable change

1.10 Talent management needs to be prioritised to retain people and bring in fresh thinking

1.1 System working has not maintained progress following the success regime

Through interviews with senior leaders from across the system, it became evident that good progress was made during the Success Regime; and many interviewees commented positively on the leadership during this time.

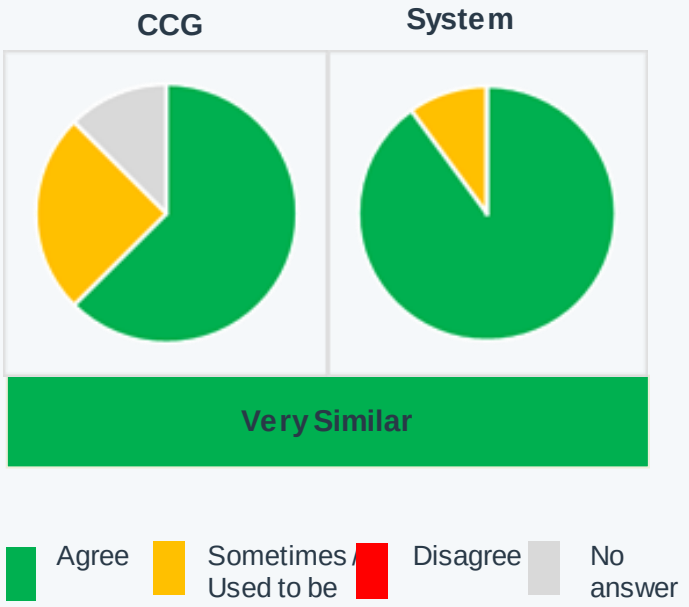
However, it was acknowledged that this progress was not enduring and as financial pressures have increased, individuals have retrenched back into their organisations, making system working more challenging. Both the CCG and wider system were in agreement on this statement.

One leader in the system made the following observation when discussing this issue, which was consistent with other views expressed during the review: -

"There is a lack of capacity and when people are pressurised they revert to organisation first, system second".

There is the impression that leaders do not consistently role model system working, for example references were made to providers investing in their own IT system and not seeking to take a joined up approach, which had an impact on the health-focused IT workforce.

In interviews, an emphasis was placed on the system missing the guiding hand of an STP leader (and supporting team), which makes it more difficult to drive system working (3.1).



Original statement
1.1 Improvements to system working were achieved during the success regime but progress has slipped, behaviours have deteriorated and in many areas of collaborative working we have gone backwards.

1.2 Key challenges are not tackled due to an avoidance of conflict

The issue of dealing with conflict was discussed in a number of interviews, with a common theme emerging that the key issues are not openly discussed. For example one leader stated:

"We don't have the difficult conversations in the right place and at the right time. There is a lack of trust between organisations. We were too reliant on [redacted] which perhaps didn't help senior leaders to step up."

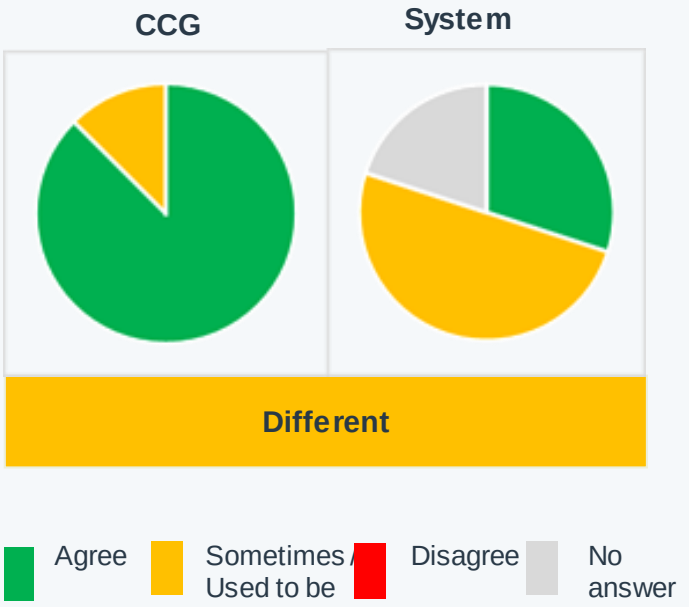
A provider chief executive said during one discussion:

"Conflict is not dealt with, people just get cross and withdraw, subsequently the issue is left to fester".

This was also evident in a number of meetings, e.g CCG/ STP Exec. 'Fair shares' was a topic that came up in a number of interviews and meetings providing an example where difficult conversations have been avoided.

In the system workshop discussion, it was clear that this was a known issue and there was agreement that it needs to be dealt with properly and not only at a surface level.

There is a perception that commissioners need to be stronger and lead on a number of the difficult conversations. It was evident at the CCG Senior Leadership Team away day that past experience of the consequences of being too challenging stops the difficult conversation and taking the tough decisions.



Original statement

1.2 Difficult conversations are avoided and therefore conflict does not get properly resolved. As a consequence issues become even bigger challenges, more significant and more difficult to resolve.

1.3 There is inconsistency in words and actions from leaders

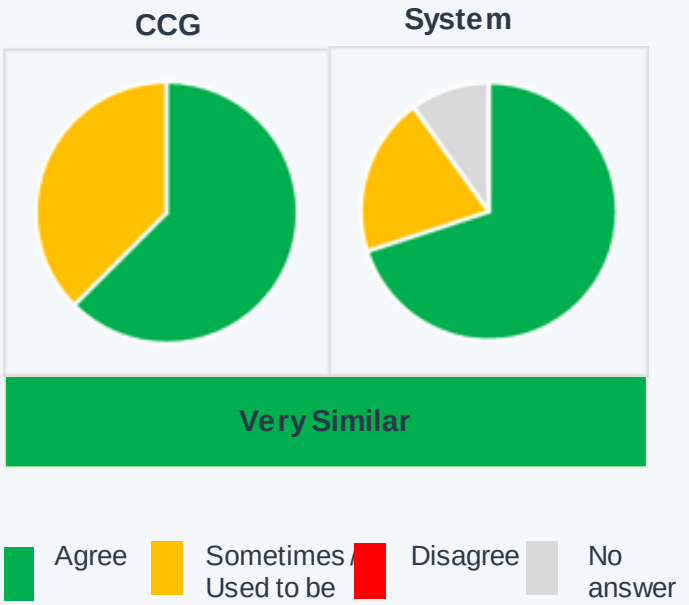
During interviews and informal conversations the issue of inconsistency between what was said and agreed in meetings and what was delivered in actions was frequently mentioned.

Many felt this was because the difficult conversations were avoided due to a lack of trust, leaders not speaking up when things are unclear and meetings not ending with a confirmation of what agreements have been reached. Consequently, these 'agreements' do not get cascaded back within individual organisations and often don't get actioned.

It was also noted in interviews and in the workshops that there is a challenge with following through on delivery. This is due to a lack of clarity on what is required as well as some capacity issues. All leaders recognised and acknowledged that this was something that was happening across all organisations. It is also possible that there is a need to strengthen change leadership skills across the system in order to drive and embed change.

One leader stated:

"The STP articulates clear leadership, however when it comes to delivery they don't follow through, e.g. the operating plan is not coming together".



Original statement
1.3 Mismatch between the words and actions of leaders in terms of system working. What is said in meetings and what gets relayed back within individual organisations is sometimes different and people don't always deliver in practice what they agree in meetings

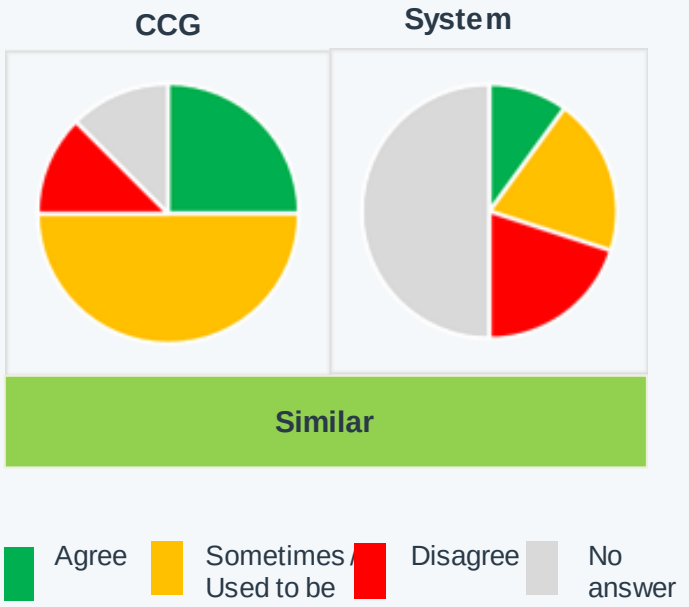
1.4 Leaders meet frequently but relationships could be better developed

In discussion during the workshops, leaders felt that they do have regular 1-1s, but that they are not as productive as they could be. This is in part because 'side agreements' can be made or discussed, which do not involve other relevant stakeholders; or the more difficult issues are not openly discussed.

It was discussed in Workshop 2 that there is a need to get a more explicit understanding of what organisational priorities are in order to better understand each others perspectives and constraints in system working.

One mechanism we have seen work in other organisations with similar challenges is to have leadership shadowing, where leaders spend the day with their fellow leaders walking in their shoes and observing the issues they face on a daily basis. This level of direct exposure can help to improve mutual understanding.

It was also noted in interviews and in the workshops that decisions get made at PDEG and then get unpicked via 1-1 conversations, following the meeting. This further adds to trust issues as decision making does not feel transparent or consistent.



Original statement

1.4 Interactions across the system happen mostly via meetings and there isn't enough done in 1-1s. As a consequence relationships are not as well-developed as they need to be and this makes it harder to get things done.

1.5.1 We have the right governance structure but it needs to work better

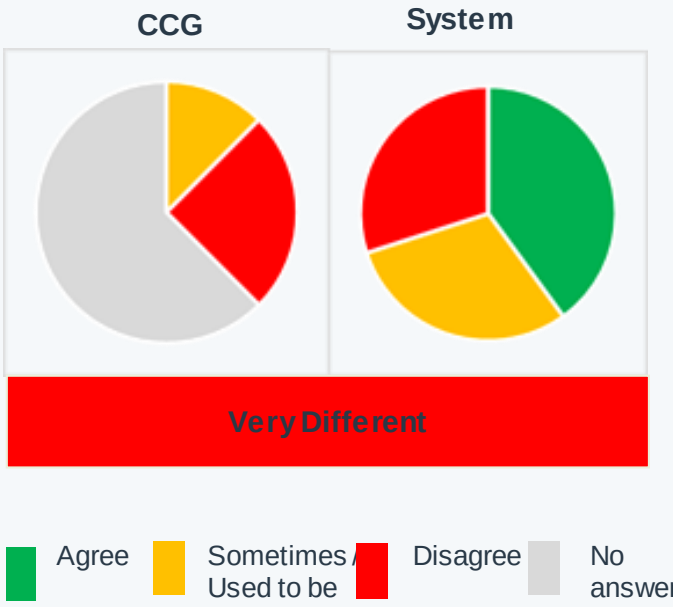
In interviews, there was a mixed view on whether the governance structure is effective.

The overall consensus was that the governance structure is on the whole about right but that it hasn't adapted over time and isn't used in the right way. Consequently, there is a need to revisit the original purpose and terms of reference to ensure that the appropriate issues are being discussed. There is also a need to be clear about how the NHS system fits with Health and Wellbeing Boards and Overview and Scrutiny Committees.

There was broad agreement to not spend time developing a new governance structure but to make the current structure work.

There was recognition in the interviews that some recent improvements had been made in Collaborative Board and that relationships are developing. People spoke positively about the influence of the Independent Chair on calling out and addressing issues, but that the STP SRO role needs the additional focus that a full time STP leader would bring.

We noted that the CCG had already made changes to its internal meeting structures, deconflicting the Executive Committee, CCG Executive-ST Directors Joint Group, and the CCG Senior Leadership Group.



Original statement

1.5.1 The governance structure with regard to groups is generally fine but we need to focus our effort on making it work better. We should avoid spending too much time on a review of structures.

1.5.2 PDEG does not drive system transformation

Across interviews there was agreement that PDEG, in particular, was not working effectively. Whilst there is disagreement between the CCG and system rankings, there is agreement that changes are necessary to make these meetings function well and a good use of peoples' time.

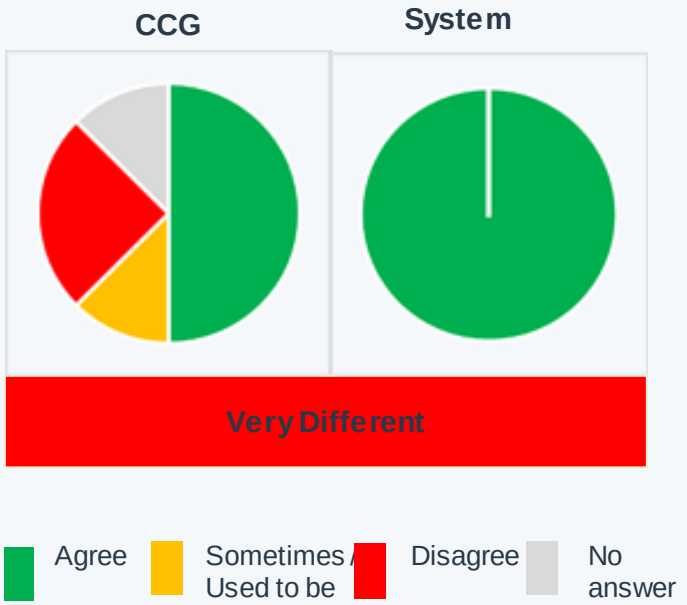
In relation to these meetings (and others), it was noted that the perception is that there are ***"packs and packs of paper"*** with many leaders making similar remarks about it being difficult to find the key issues hidden in the volume. This was common across CCG and STP meetings, often with the content of the same packs being produced multiple times, resulting in different people in different meetings discussing the same issue.

The knock on effect of this was profound, with leaders finding it difficult to be fully informed before arriving at the meeting and then time being used in the meeting on bringing people up to speed on the issue. Whilst there is generally good attendance at these meetings the level of engagement across the system was questioned, with one leader noting:

"Visibility and participation are good, people turn up but how bought in are the level below Chief Execs?"

We noted that the STP did work to develop the MOU and a set of values, but these have largely been forgotten and are not being used. This provides an example of how things get worked up and developed but don't get fully implemented, characterised by one leader as:

"We love a vision and a plan. When it gets to a difficult decision we go back to developing a vision and a plan. We have difficulty seeing things through"



Original statement

1.5.2 PDEG and Collaborative Board are not used effectively to make progress on resolving key issues and developing solutions.

N.B We were unable to observe PDEG or Collaborative Board during the review.

1.6 There is a lack of ownership and solution-focus to address challenges

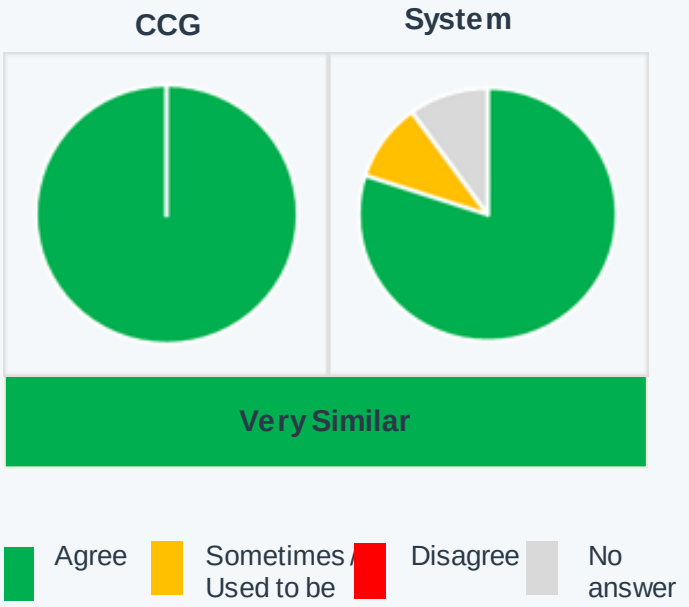
In meetings we observed, we noted there was a lack of focus on discussing critical issues and a lack of a problem solving approach. We observed a number of discussions on the performance issues and financial gap across Devon yet we didn't observe a focus on developing solutions to address the issues.

This was noted particularly in the Governing Body, CCG committees and in a number of the system meetings where the focus of the discussion was on highlighting and analysing the problems rather than developing ideas to address them.

For example in most meetings when the financial problems were discussed, there were very few (although it was noted that there were some, but they were often lone voices) meeting participants who were prepared to stand up and say ***"this is not good enough"*** or ***"we have to get on top of this and turn it around"***.

Most comments tended to be in recognition of how hard the challenge was and how difficult it would be to address, making it harder for those who were keen to address the challenge, as they were isolated in their stance.

There is acceptance that there is a 'learned helplessness' and/ or 'crisis mentally' culture in Devon, where the system gets struck in finding ways to navigate challenges and often allows issues to develop in more significant problems before they are challenged.



Original statement

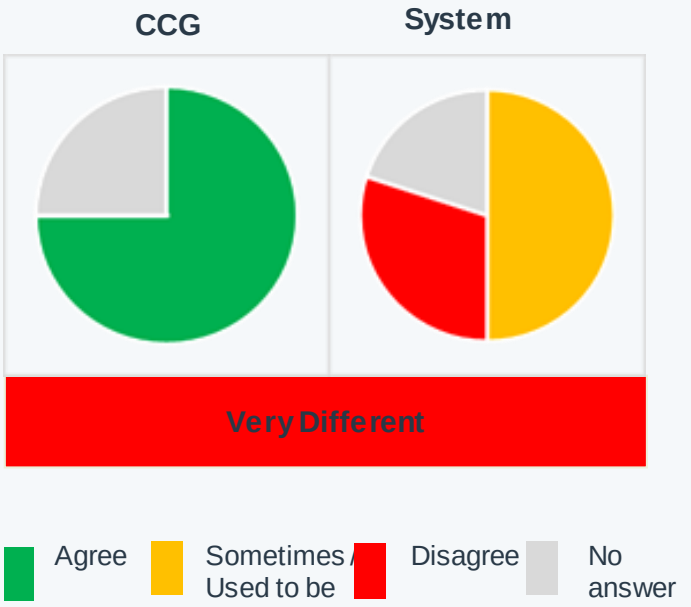
1.6 There is a lack of ownership across the system of the biggest challenges and there is a lack of urgency on solutions and focus to address these challenges.

1.7 There is a lack of coming together to work as a system

In interviews, we frequently heard how the system comes together well in a crisis but is challenged to do this for longer-term planning. However, there was little acceptance of this view in the system workshop. The view expressed was that the system does not come together well in a crisis or for longer-term planning.

At the CCG senior leadership team away day, it was highlighted how the CCG are frequently stepping into the provider space to resolve crises, which is not helping the system to resolve some of these challenges in the longer term.

There is still significant work to be done to develop productive and effective ways of system working; ensuring that all stakeholders are clear on priorities and their role in delivering better outcomes for the people of Devon.



Original statement

1.7 In a crisis, the system comes together and works effectively, but we don't do this when it comes to longer-term strategic planning.

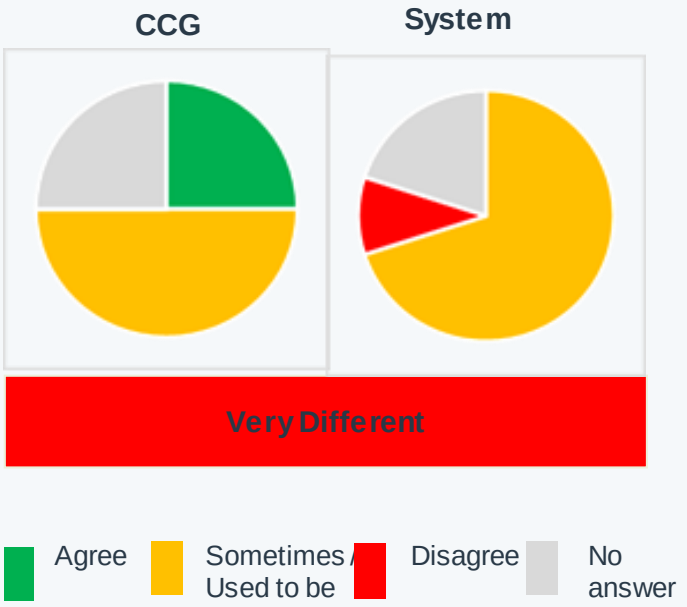
1.8 There is followership but not enough to achieve system outcomes

There are some examples of leaders 'following' in order to support others to achieve outcomes. An example of this is with the recent decision around commissioning of services for adults with autism.

Where the lack of followership appears to arise most is when requiring provider organisations to work differently as a result of decisions to deliver more person-centred, out of hospital care. Since the reality of this means releasing money to other parts of the system, it makes it difficult for leaders to sign up to and agree.

There is evidence of some provider and commissioning organisations finding it difficult to put people at the centre of decision making. This is noted from interviews, meeting observations and workshops.

It is noted that there is some difference in opinion between the CCG and system in terms of how they scored this finding, which may also demonstrate a lack of clarity on what followership looks like in practice.



Original statement

1.8 There is no followership, with leaders being unprepared/ unable/ unwilling to share leadership and/ or provide support to others to achieve outcomes.

1.9 A greater level of system leadership skills are required to enable change

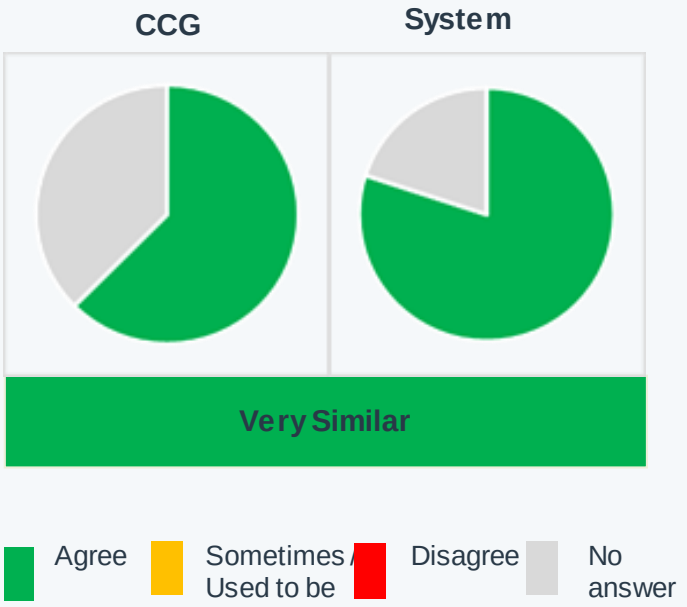
In interviews it was noted that there is a gap in terms of system leadership. Whilst Chief Executives do meet frequently, the influence and engagement required to deliver on system working is ineffective.

Whilst people recognise that system leadership is not about one person or one role, focus is placed on filling the STP role to deliver transformation; and change the dynamic in the current ways of working.

During the workshop not everybody prioritised forming a view on this issue, hence the grey areas in the charts. However, this area is unusual compared to others in the 100% agreement to the statement where people did respond.

The absence of amber and red in the charts is a strong reflection of the system recognition that any future STP/ ICS leadership role needs to be populated by somebody who is a networker, influencer and relationship builder; rather than somebody who is perhaps more autocratic or directional in their style of leadership.

This connects to findings under KLoE 3.



Original statement
1.9 System leadership is about soft power therefore requires a skilled influencer with strong engagement skills.

04

KLoE 2: CCG leadership capacity and capability

KLoE 2 key findings

2.1 Turnover in CCG leadership has affected its ability to act as a system leader for Devon

2.2 Many CCG senior leaders are acting/ interim or new in role and need to build credibility with other system leaders

2.3 Devon is a large, complex health and care system that requires an appropriate commissioning structure

2.4 The thee CCG director portfolios of commissioning, transformation and strategy need greater definition and delineation

2.5 The development of localities within Devon requires greater leadership capacity

2.6 The role of CCG clinical locality chairs – and clinical leadership within localities in general – requires greater clarity

2.7 The contribution of local authorities is fundamental to the success of genuine population health management

2.8 The inter-relationship between the NHS and local government in Devon must continue to develop and deepen

2.9 There is not yet clarity on the function of the CCG within a Devon ICS, although strategic commissioning remains vital

2.10 The Devon STP does not yet have a widely shared and embedded set of system values and behaviours

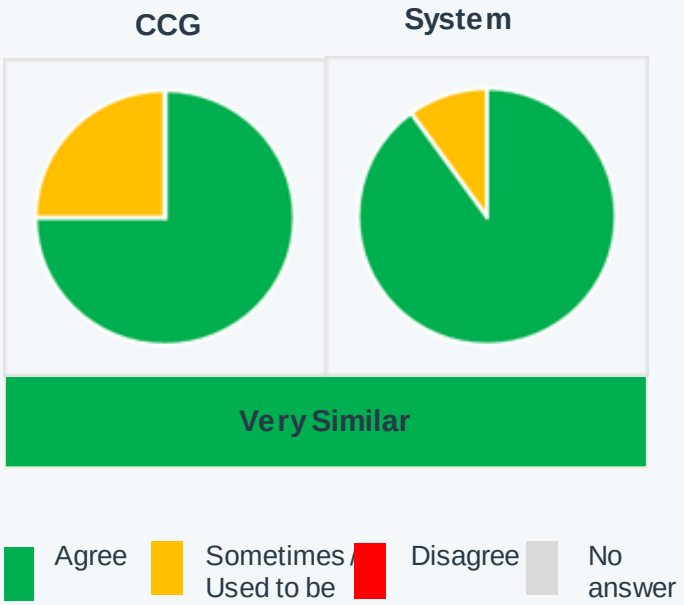
2.1 Turnover in CCG leadership has affected its ability to act as a system leader for Devon

The two CCGs – now merged – have had a number of changes of Accountable Officer (AO) over the past two years. In addition, the process of merger has, inevitably, made the CCGs more inward-looking.

There was broad consensus between CCG leaders and system leaders on this finding.

Now the merger is complete, there should be a period of leadership stability, although a large number of interim roles in the structure is not the ideal platform for long term direction and stability.

Mirroring the tenure of the interim AO with that of the interim STP SRO would help with stability and facilitate bringing the two roles together in the future, if desired (3.2).



Original statement
2.1 The high level churn in CCG leadership structures has inevitably led to some instability, uncertainty and this has impacted on the CCG's ability to lead the Devon system.

2.2 Many CCG senior leaders are acting/ interim or new in role and need to build credibility with other system leaders

With the interim Accountable Officer being an internal appointment, this creates two further interim appointments (Director of Commissioning and Director of Strategy). In addition, there have been new and first-time appointments to the CCG Governing Body and Executive. One system leader said:

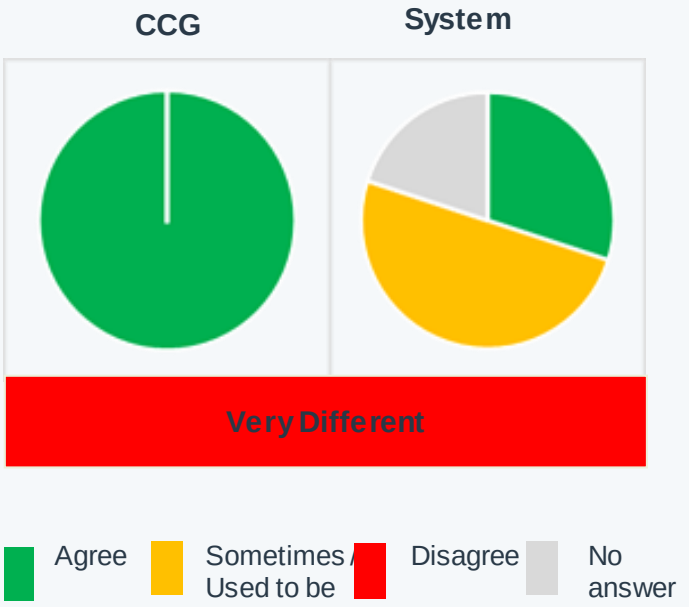
"They are a new team so there is lots of learning for them. Many of them came from South Devon so they need to learn how to work over a bigger footprint"

This issue is more recognised by CCG leaders than system leaders, reflecting the nature of the positive relationships and the willingness of leaders to work with the current CCG team.

Stability of leadership will be important to allow CCG leaders to grow into their new roles and, in particular, become more outward-facing. The CCG, and wider system, should therefore prioritise securing substantive arrangements for as many roles as possible, as quickly as possible to embed security in the structure and operating model.

This is important both for all of the individuals involved – not only to reduce the diverting burden of role insecurity – but also to embed credibility to the role and avoid the potential of other system leaders believing that changes will be unpicked once a substantive postholder is in place.

However, we recognise the complications in achieving this in the short term.



Original statement

2.2 Many of the CCG leaders are in interim roles or new to director level roles so collectively the team needs to build track record and credibility to secure the confidence of providers in the system.

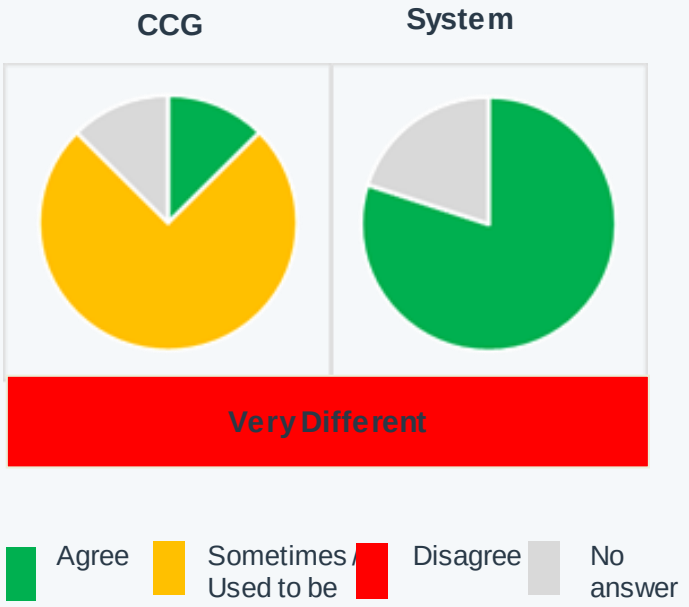
2.3 Devon is a large, complex health and care system that requires an appropriate commissioning structure

Many of the new CCG Executives have come from South Devon and Torbay, a smaller more integrated system. At the same time, some leaders felt the 'federated model' at NEW Devon was a significant contributor cause of its challenges which ultimately led to the Success Regime process.

This finding was perceived to be more of a current/ ongoing issue by system leaders than CCG leaders. Relating this back to KLoE 2.2, this suggests that providers are ready to work with the commissioners but that the commissioners need to be able to adapt their approach to the current challenges.

This is mirrored in both groups reflections that changes to approach are needed in the current environment.

Greater leadership of localities (2.5) will require Devon CCG to evolve its operating model to fit with the scale and complexity of the whole of Devon. CCG leaders (Governing Body, Executive and locality 'triumvirates') will need to address this through their leadership development programme.



Original statement

2.3 The size of organisation and scale of challenge is new to many of the current CCG leaders as they have come from a much smaller and integrated system. Organisation and personal development needs to ensure the 'mental model' of commissioning reflects this new environment.

2.4 The thee CCG director portfolios of commissioning, transformation and strategy need greater definition and delineation

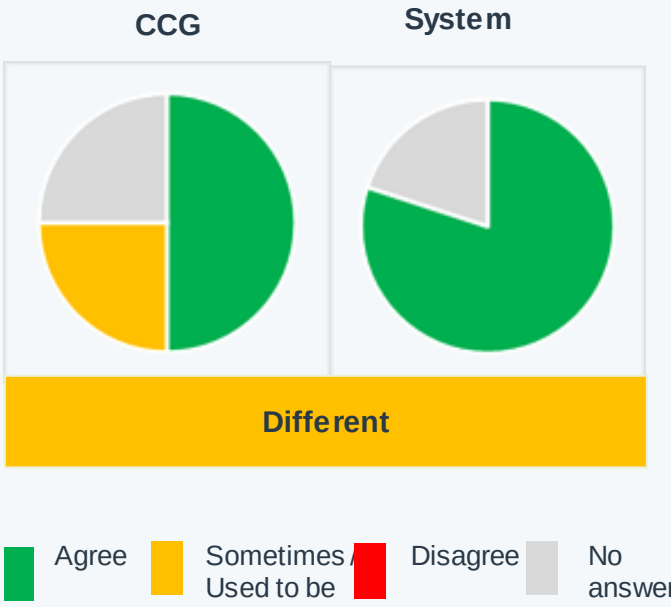
When asked, CCG Executives explained the Director of Commissioning and the Director of Transformation were really one job, split between two people. In addition, the Director of Commissioning continues to perform functions of the Director of Strategy. The Director of Transformation has a specific locality focus, at least initially.

This was an independent observation made by PA, but was corroborated by discussions observed at the CCG Governing Body in April.

There was a reasonable degree of consensus between CCG leaders and system leaders.

The Accountable Officer has already recognised that the title of Director of Transformation is not representative of the actual role and, therefore, should change, potentially to:

- Director of Commissioning – Western, if the main focus will continue to be on the locality commissioning model; or
- "Director of the Programme Delivery" if the main focus is on delivery of specific programmes that reach beyond the locality



Original statement

2.4 There is a degree of overlap between three closely related director portfolios: Commissioning, Transformation and Strategy which has the potential to lead to confusion for internal and external stakeholders.

2.5 The development of localities within Devon requires greater leadership capacity

Linked to 2.4, the current CCG matrix leadership model of functional and locality responsibilities leaves the leadership of localities feeling under-powered.

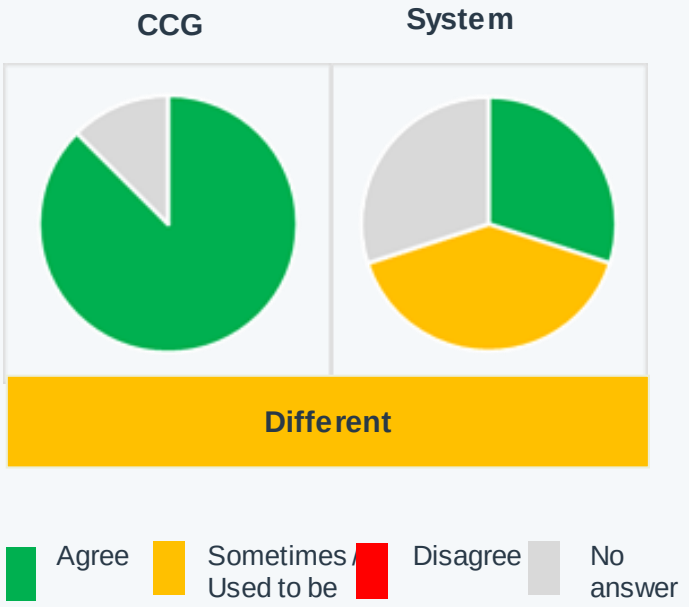
CCG Clinical Representatives described the Executive leadership of localities as a ***"link person"*** or a ***"figurehead".***

As the 5th largest CCG in the country, recently emerged from a Success Regime, with a number of significant ongoing financial and performance challenges – the functional executive roles are challenging in their own right.

Adding to these roles the locality responsibilities, whilst possibly the right model to aim for in the longer term, is likely to be difficult to achieve here and now. Trying to do this risks leaders not being able to be as effective as possible in either functional or locality role. There is a need to reflect on the deliverability of this target operating model as a consequence.

There were different views between CCG leaders and system leaders. This probably reflects the phrasing of the original statement as being more about the CCG leadership than the wider system.

Going forward, the leadership of localities will need to be a shared task between commissioners and providers. The transition for provider leaders, from being 'leaders of organisations' to leaders of localities, should not be underestimated.



Original statement
2.5 Commissioning leadership of place is likely to be underpowered for what is required to get to an ICS. Dual roles for directors alongside leadership of place is going to be challenging and it is not yet clear how wider CCG resources will be deployed to localities.

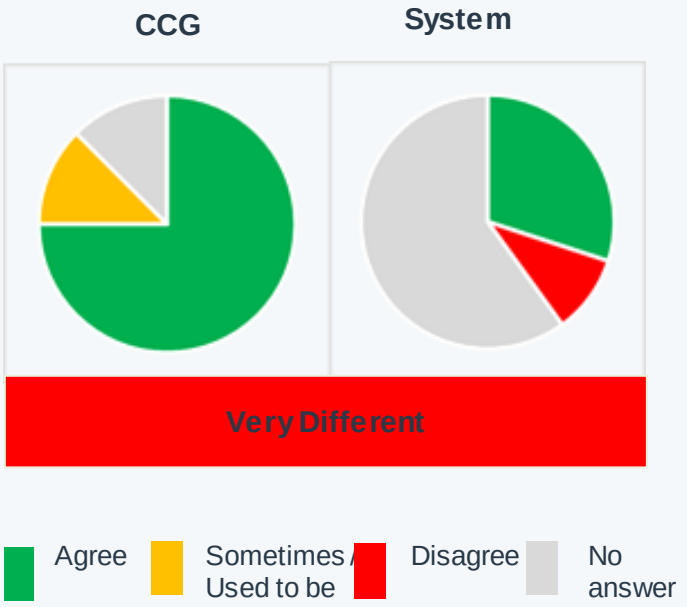
2.6 The role of CCG clinical locality chairs – and clinical leadership within localities in general – requires greater clarity

CCG Clinical Representatives described their role differently, reflecting different historic practices in different localities. There are (at least) four different clinical leadership roles within primary care alone: CCG clinical representatives, CCG employed GP leads, newly appointed STP Primary Care Medical Director, and soon to be appointed PCN Clinical Directors.

Observations at the CCG Governing Body in May suggested the unique role of CCG Clinical Representatives is as elected representatives of the CCG GP membership.

There were different views between CCG leaders and system leaders. This probably reflects the internal focus of the original statement.

Distributed leadership can work well in complex systems, but clinical leadership cannot be effective when it is disassociated or ambiguous.



Original statement

2.6 The role of clinical locality chairs, at the GB and at place-level, needs to be developed further. Are they: representative roles (of the GP membership); wider clinical leaders; and/or 'clinical non-exec's'?

2.7 The contribution of local authorities is fundamental to the success of genuine population health management

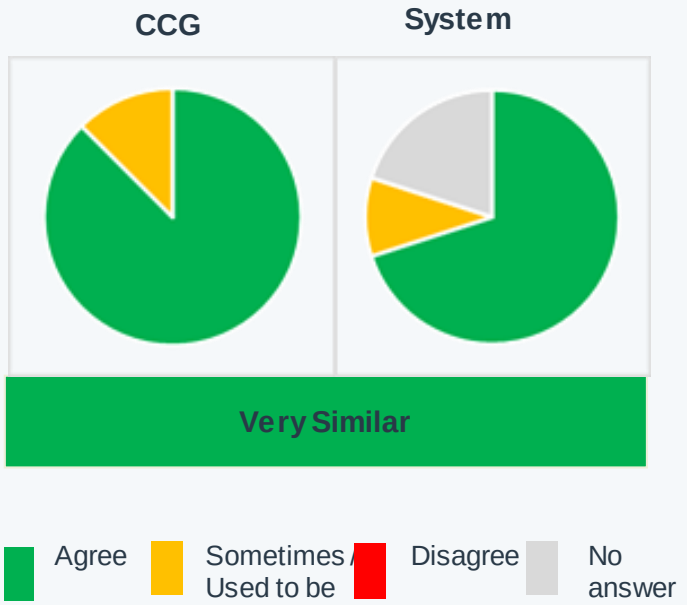
The long-term success of any Integrated Care System (ICS) will depend on the 'left-shift' to wellbeing, prevention and the wider determinants of health. Local authorities have a new and unique contribution to make to these areas.

Both local authority leaders (in interviews and workshops) and some CCG Clinical Representatives advocated for a greater contribution by local authorities to any future ICS. The local authorities made a positive contribution and were active participants to all the workshops, reflecting a level of collaboration and willingness to work together that is not always prevalent in other systems.

Furthermore, the strong relationships between Local Authority and CCG commissioners was particularly apparent in Plymouth and Torbay and the new joint commissioning roles with Devon CCG are also a positive development.

There was broad consensus between CCG leaders and system leaders on this finding.

This finding provides the reason for continuing to address the inter-relationship between the NHS and local government (2.8).



Original statement

2.7 Relationships between the CCG and LA's is crucial to the success of an ICS model, predicated on PHM, prevention and the wider determinants of health. CCG-LA relationships are improving but there is inconsistency across the CCG area in terms of relationship maturity and trust.

2.8 The inter-relationship between the NHS and local government in Devon must continue to develop and deepen

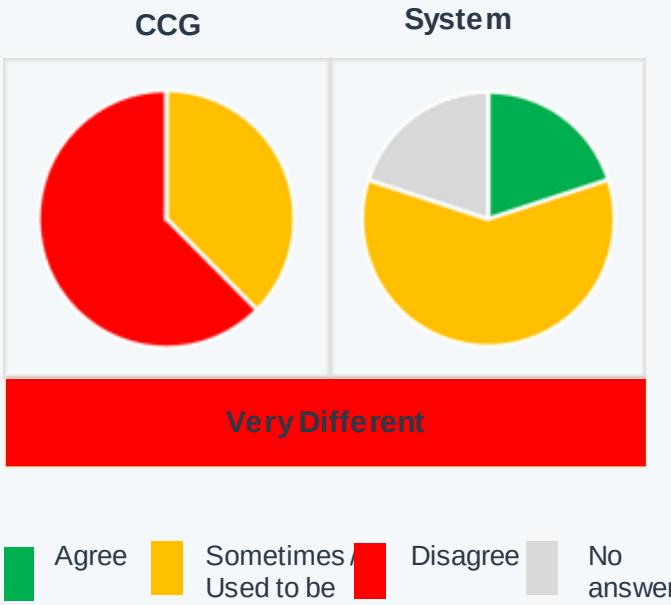
Building on 2.7, and regardless of how localities fit with local political/ administrative boundaries; health and social care services should continue to integrate further.

The CCG and local authorities have taken practical steps drive greater integration through joint posts, the Integrated Commissioning Executive, and the Better Care Fund.

There were different views between CCG leaders and system leaders. This probably reflects a difference of experience between CCG and local authority leaders of the Success Regime, STP and NHS operational planning/ financial negotiations.

Additionally, the subtle change in working to the statement following discussion at the first workshop will contribute to the differences. In the first workshop, participants were particularly keen to emphasise that they did not see culture as being the barrier to progress, but more a lack of understanding.

Health and Wellbeing Boards can be powerful fora for bringing NHS and wider public service partners together. However, they would need to develop their role in order to become effective leadership groups of localities in Devon.



Original Statement

2.8 The cultural differences between the NHS and Local Government are barriers to progress. Joint posts help build connections, mutual understanding and aligned, but don't help with building additional capacity.

Revised statement

2.8 Differences in culture and respective understanding between the NHS and Local Government can be barriers to progress. Joint posts help build connections, mutual understanding and aligned, but don't help with building additional capacity.

2.9 There is not yet clarity on the function of the CCG within a Devon ICS, although strategic commissioning remains vital

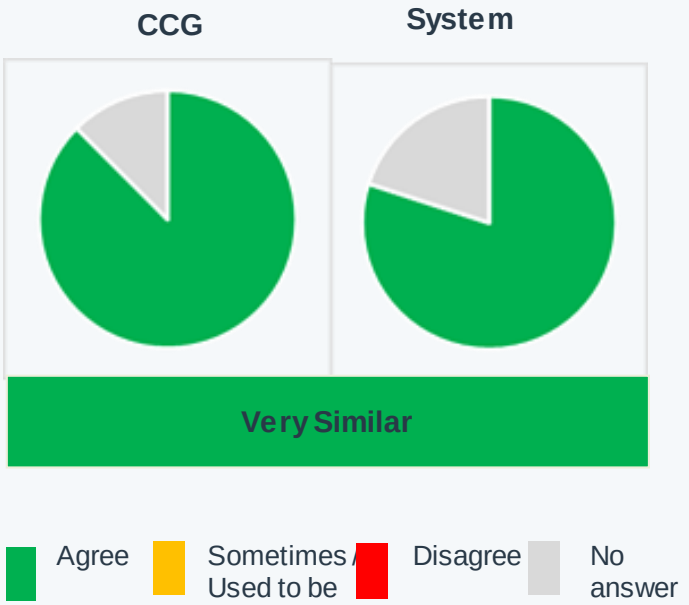
Whilst strategic commissioning seems as important as ever to delivering the NHS Long Term Plan and a successful ICS in Devon, policy makers and regulators nationally, and CCG and system leaders locally, continue to grapple with the synonymity between strategic commissioning and system leadership.

There was broad consensus between CCG leaders and system leaders on this finding.

In particular we frequently observed different people in different meetings reviewing very similar (and voluminous) report packs and having very similar conversations. For example the CCG Quality Committee, the STP Performance Group and the CCG Governing Body. On occasion this was also the case with the same people in different meetings – however that is less of a concern because the duplication and differences can be recognised and addressed.

Some other systems have started to amalgamate meetings to reduce duplication – for example we know of at least one other system that now only has a System-wide Quality Committee – the CCG meeting now involves providers rather than having a separate STP Quality Meeting running in parallel.

Notwithstanding findings 2.1 and 2.2, Devon CCG has an important role to play over the medium-term to help establish and embed high-performing localities across Devon.



Original statement

2.9 There is duplication and inefficiency between many of the CCG, STP, GB and locality meetings. There is a need to review and understand how these meetings support the system to achieve its aims.

2.10 The Devon STP does not yet have a widely shared and embedded set of system values and behaviours

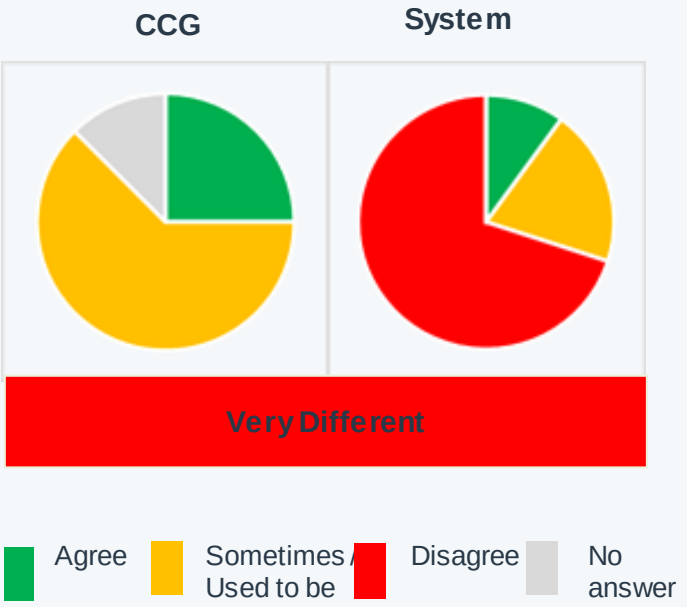
Complex systems, such as an STP or an ICS, are better governed/ regulated through a limited set of shared rules, than through lengthy guidance/ instruction.

In workshop 1b, we observed a conversation that identified that the CCG values should not necessarily be synonymous with system values, despite the perceived CCG system leadership role. Indeed the CCG Executives themselves identified that the CCG values were only ever intended to be organisational (and hence inward looking) values rather than outward facing values.

This led to a conversation about whether there needed to be system values, the subsequent recollection that a set of system values had been created and a realisation these were no longer actively used by the system.

There were different views between CCG leaders and system leaders. This almost certainly derived from the phrasing of the original statement, but the discussion around remembering the work that had been done on system values and a re-commitment to live with them resulted ultimately in leaders reaching a very similar end position.

The Devon STP should clearly resurrect and revisit and then put to good use, the work done on the Memorandum of Understanding, as part of the Success Regime.



Original statement
2.10 There is a challenge to get the CCG values to be shared and adopted across the Devon system.

05

KLoE 3: System leadership roles in a Devon ICS

KLoE 3 key findings

3.1 The Devon STP is urgently missing the 'guiding hand' of a system leader in a dedicated STP SRO

3.2 Most people felt a combined CCG AO – STP SRO appointment could work, if system leadership was synonymous with strategic commissioning

3.3 There was little appetite for an 'executive chair', but also little consensus on the formal powers of an ICS leadership team

3.4 There are clear implications of a combined executive appointment that require further discussion

3.5 A system leadership/ strategic commissioning function needs to be properly resourced to be successful

3.6 Now and in the future, leadership in localities and neighbourhoods will be as important as at system-level

3.1 The Devon STP is urgently missing the ‘guiding hand’ of a system leader in a dedicated STP SRO

Since the departure, in November 2018, of the combined CCG AO-STP SRO, CCG and system leaders alike miss the focus that a dedicated STP SRO role brings.

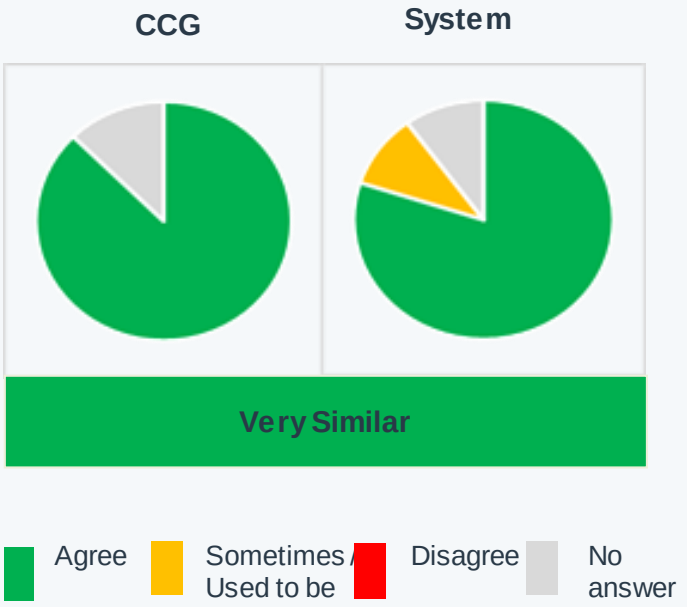
There was broad consensus between CCG leaders and system leaders on this finding. However, discussion during workshop 1b revealed there was less consensus about what formal powers that system leader should have and how they should be positioned in relation to existing organisational leaders.

The original dedicated Success Regime STP-SRO and the most recent combined CCG AO – STP SRO provide two different models for system leadership in Devon.

What was consistently highlighted was the importance of existing leaders having a role in the appointment and selection of the system leader, even if they did not ultimately have the final say or a ‘veto’ on their appointment.

This issue was emphasised strongly in the context of selecting somebody who people feel they can work with, somebody who recognises other individual leadership responsibilities and somebody who is willing to listen, build consensus and be supportive and consultative in their approach.

We note that the STP Independent Chair, along with the NHSE/ I regional team, have already taken steps to appoint an interim dedicated STP SRO for 12 months, extendable for a further 6 months.



Original statement

3.1 The Devon system is missing the ‘guiding hand’ of a system leader and this gap needs to be filled with some urgency.

3.2 Most people felt a combined CCG AO – STP SRO appointment could work, if system leadership was synonymous with strategic commissioning

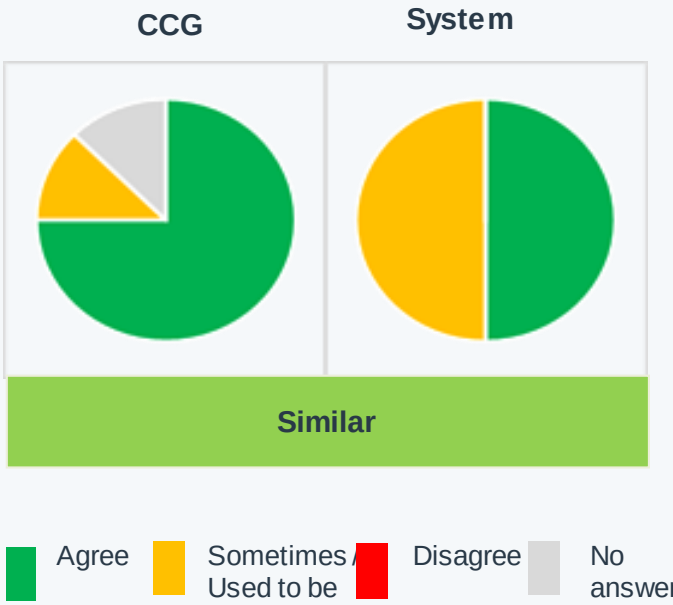
Key to making a joint appointment work was that: -

1) The CCG became a strategic commissioner.
2) Strategic commissioning became synonymous with system leadership of the STP/ ICS.

There was a good degree of consensus between CCG leaders and system leaders. Divergence of opinion centred around whether bringing the two roles together could or could not be achieved in the shorter-term.

A legitimate concern was highlighted that, given the membership structure of CCGs, it would be difficult for the CCG AO to also be the STP SRO/ ICS CEO, because they could always be accountable to a particular provider group. We have frequently observed across CCGs and systems the challenges that many GP's face in distinguishing their responsibilities as a commissioner and their much more commonly understood (and practised) responsibilities as a provider of primary care.

Ensuring that clear distinction and genuinely robust governance arrangement would be required to ensure that the combined role could be delivered effectively.



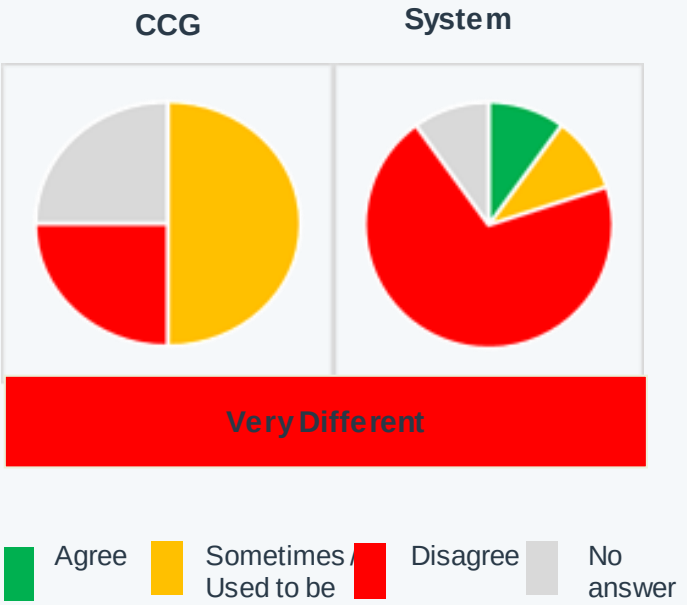
Original statement
3.2 An integrated role of CCG AO and STP SRO is the right solution for the longer-term, but is not a achievable in the shorter-term and therefore a transition period is required.

3.3 There was little appetite for an ‘executive chair’, but also little consensus on the formal powers of an ICS leadership team

Few leaders were attracted to the idea of an Executive Chair. Despite this, to some degree, this is the current situation, with the STP Independent Chair filling some of the leadership vacuum identified in 3.1.

The level of resistance to this idea was more prevalent amongst the wider system leadership group. This is likely to reflect the strength of views from both Local Authority and Provider leaders towards not wanting to have a single authority with significant formal levers over their own constitutional arrangements.

Without any significant support, an Executive Chair would not be the right option for Devon, but its exploration was a useful exercise in helping to uncover views and explore views about what system leadership means in practice to Devon leaders.



Original statement

3.3 Recognising that an STP-SRO/ ICS-CEO would have limited formal authority and would need to work through soft power, an ‘executive chair’ could be an option for the STP/ ICS. [Although this may present upward governance issues]

3.4 There are clear implications of a combined executive appointment that require further discussion

Because combining the roles of STP SRO and CCG AO would create a dual accountability for the most senior STP/ICS executive leaders, this could have 'knock-on' implications for the roles of STP Independent Chair and CCG Chair roles.

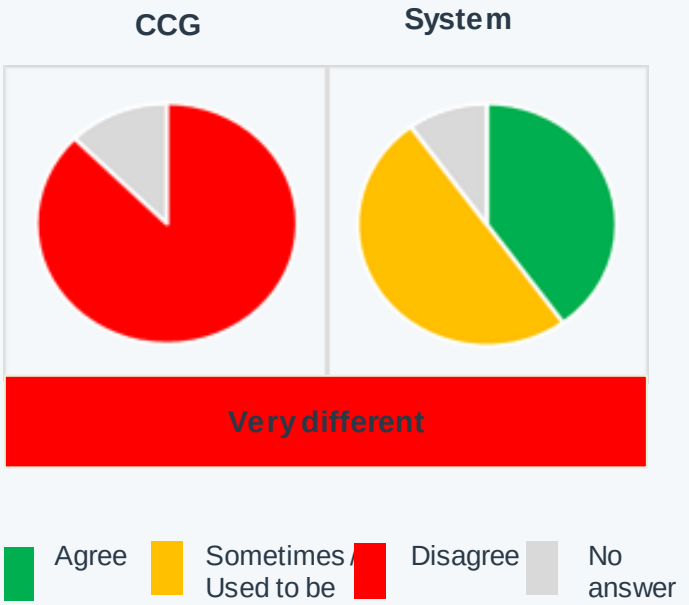
This was explored during the workshops as a potential model. There were different views between CCG leaders and system leaders, but this will be partly created by the changes to the statement wording, as a result of the discussion in workshop 1a.

The use of 'could/ should' terminology was something that was not considered attractive by the CCG leaders, although a discussion emerged that it depended on whether it lead to the STP Chair being imposed as the CCG Chair, or vice versa – which clearly had fundamentally different connotations, both constitutionally and culturally.

National policy requires every STP/ICS to have an independent chair. However, a degree of join up might be possible – for example by the STP chair having a Lay Member role on the CCG Governing Body with Deputy Chair responsibilities, but this was not explored in the workshop discussions.

The STP independent chair may also wish to explore appointing independent chairs at locality level.

In our view, the 'triumvirate leadership model' of executive, non-executive and clinical leadership that pervades different levels of the CCG is a strong one. Therefore, the role of STP Medical Director(s) needs further exploration as part of the STP/ ICS system leadership.



Original Statement
2.4 The STP chair and CCG chair roles could/ should be combined; [Although, this may raise issues with national policy and CCG constitution/ legislation].

Revised statement
3.4 The potential to combine the STP chair and CCG chair roles in some form should be explored. [Although, this may raise issues with national policy and CCG constitution/ legislation].

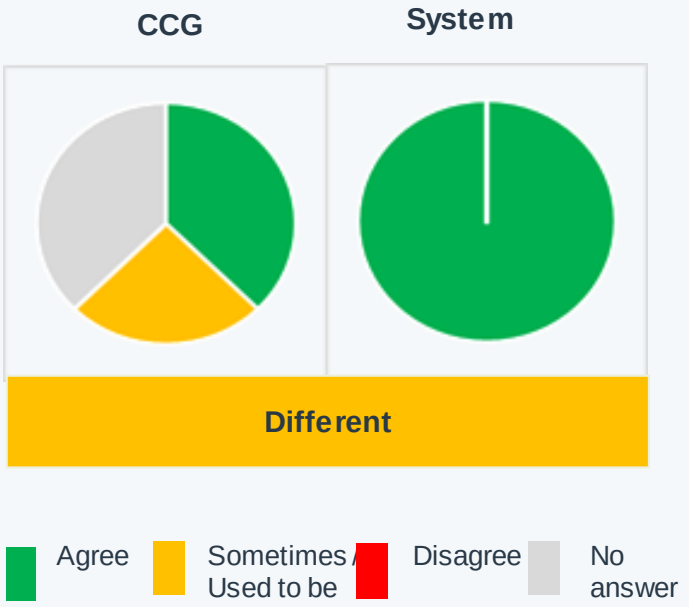
3.5 A system leadership/ strategic commissioning function needs to be properly resourced to be successful

The review originally sought to answer specific questions about individual leadership positions. However, Devon leaders were clear the challenge was broader, encompassing whole functional layers and teams.

A number of interviewees drew a comparison between the amount of strategic planning resource during the Success Regime and now.

There was some difference of opinion between CCG leaders and system leaders, which probably originates from several CCG leaders already holding joint appointments with the STP.

In fact, there was near unanimity that, in order to be successful, a system leadership/ strategic commissioning function needed to be properly resourced.



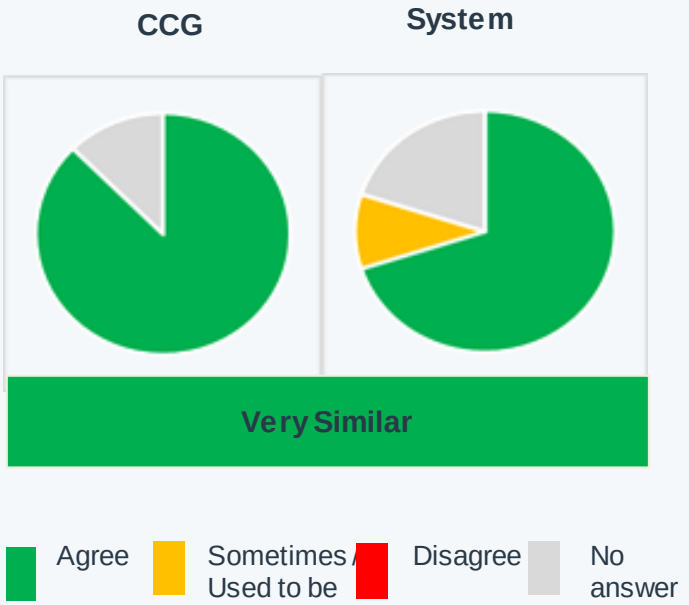
Original statement
3.5 The system level needs to be properly resourced – an independent chair and CEO are not sufficient on their own to deliver the system transformation agenda. [But this must not bring an additional layer of bureaucracy].

3.6 Now and in the future, leadership in localities and neighbourhood will be as important as at system-level

Similar to finding 3.5, the review originally sought to explore leadership at system level. However, Devon leaders were clear leadership at locality and neighbourhood levels were equally important and only by building effective leadership throughout the different layers of Devon would there be positive progress.

There was broad consensus between CCG leaders and system leaders on this finding.

Locality leadership will become a shared responsibility between CCG Directors of Commissioning, local authority leaders (primarily DASSs), and NHS provider CEOs. PCN Clinical Directors could become influential leaders at neighbourhood level, but will need the investment in their development to allow them to be effective.



Original statement
3.6 The leadership of place and neighbourhoods (system wide and CCG) is as important as the tier-one level organisation leadership. The role PCN clinical directors needs to be included as part of the whole.

06

KLoE 4/ 5: Becoming an ICS and Developing system, place and locality working

KLoE 4/ 5 key findings

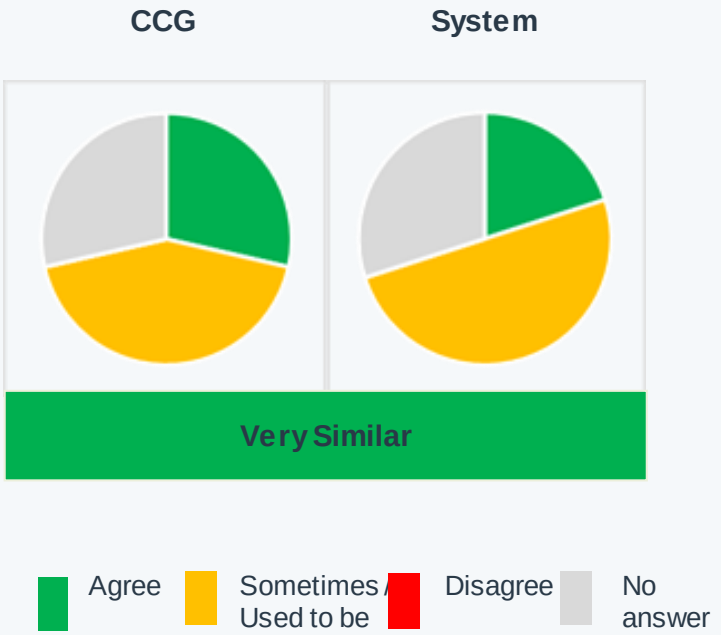
- 4.1 Sustainability of system working improvements
- 4.2 Preparedness for place based working
- 4.3 Development of Primary Care Networks
- 4.4 Long term financial planning
- 4.5 The definition and subsequent development of place
- 4.6 Development of local care organisations/ partnerships
- 4.7 ICS governance structures
- 4.8 Clinical and patient focus during ICS discussions
- 4.9 Middle management and delivery capacity in the STP
- 4.10 The potential for regulatory devolvement
- 4.11 Strategic commissioning beyond the Devon STP border

4.1 Some of the improvements achieved during the Success Regime has been durable, but this is not universally the case

There was mixed opinion as to the durability of the Success Regime impacts. KLOE 1 identified that most system leaders and more than half of the CCG leaders felt that behaviours and ways of working had not been maintained or, in some cases, had slipped back. However, there was a significantly smaller proportion of leaders who felt that actual service improvements had not been maintained.

This is likely to be reflected by that fact that good progress has been made in some areas, such as reducing the number of 52 week waits and maintaining performance across a number of key headline indicators.

However, it is notable that across both workshop nobody disagreed with the statement that improvements made under the Success Regime had been translated into sustainable improvements.



Original statement
4.1 The improvements made under the Success Regime have proved not to be durable or robustly sustainable.

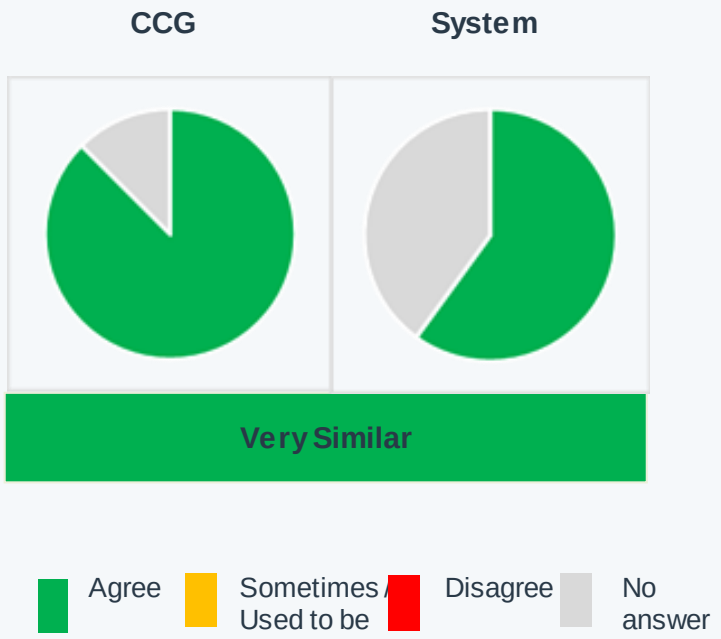
4.2 Existing structures for locality working need to be significantly developed before they are ready to take on additional 'place-based' responsibilities

Across the entirety of the Devon STP, there are very different histories around place-based working. Within Plymouth there are strong local relationships with joint commissioning structures and the procurement of an integrated care provider in the coming 12 months.

Torbay has historically been seen as a national exemplar in how to create and deliver integrated care across health and social care system. Within the previous NEW Devon CCG structure, there were clearly established locality working arrangements, although some questioned whether the right balance was struck between locality and corporate focus and the extent to which this may have contributed to some of the historical financial challenges.

There are currently a number of locality based structures that bring together local authorities, CCG, providers, primary care, voluntary sector and other stakeholders. However, it is recognised that these are some way off being ready to take executive powers and hold multi-year capitated budgets or make significant strategic local decisions on priorities and be accountable for local service structures.

We observed one locality meeting and noted a strong focus on discussing local issues and attempts to come up with local solutions. However, this 'relationship building and ways of working' approach would require significant development and very different governance structures to enable it to be anywhere near ready to take responsibility for local budgets and service decisions worth £m's.



Original statement

4.2 Whilst there are some groups in place in locality areas they will need development before they are ready to take on multi year, placed based capitated budgets or be responsible for locality service planning and delivery.

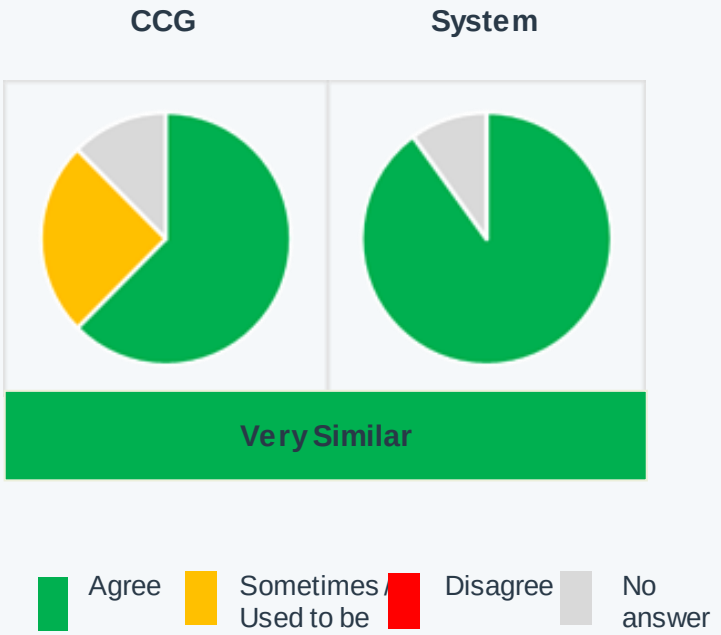
4.3 Primary Care Networks are in their infancy and will need time before they are in a position to take on additional responsibilities

Arrangements for Primary Care Networks are still being developed across the county and consequently it was difficult to make an objective assessment of their readiness to engage with the wider system and become equal partners in the development of services in their localities.

There is widespread agreement across the system that PCNs are an essential component of building an Integrated Care System and that PCN Clinical Directors need to be strong voices at neighbourhood-level.

As the concept of "place" is developed across Devon, it is important to ensure that PCNS are a constituent part in the same way as LA catchments, Acute Flows or towns and villages. Continued use of the current description will help ensure this is embedded:

- 1 System
- 3 Pooled Funds (Local Authority Footprints)
- 4 Acute / Community Footprints
- 31 PCNs
- 52 Towns and Villages



Original statement
4.3 PCNs and primary care at scale feels underdeveloped in some areas. The new roles of clinical directors need to be supported to describe and accelerate the role of PCNs in coastal and market towns.

4.4 The system is too driven by short term financial planning and addressing the financial 'gap' rather than taking a fundamentally more strategic perspective

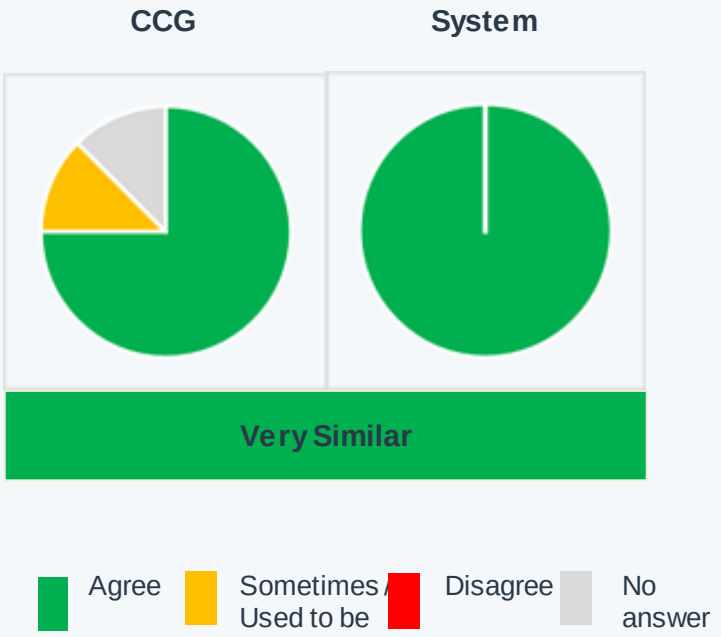
There was widespread agreement from leaders across the system that long term strategic planning is not the predominant approach being pursued to resolve the financial gap.

Furthermore, multiple leaders expressed frustration both within meetings that we observed and during 1:1 discussions, about the system's propensity to focus on the "*gap*" and largely forget the "*billion pound plus*" that is committed to providing services.

They recognised the dangers and difficulties of moving away from, simply resolving the short term issues. The challenges around agreeing the 2019/20 operational plan were almost entirely down to being unable to agree a suitable system financial plan for 2019/20.

A significant proportion of the financial gap can be traced through an interesting path of providers seeking funding growth to be able to cope with the large projected increases in demand, which they felt the CCG had done insufficient work to mitigate through demand schemes; whereas the CCG felt that large parts of the growth were the result of demand growth that was predominantly in the gift of providers to control (for example C2C referrals and OPD follow ups). When talking about system working, one provider chief executive said ***"unfortunately organisational sovereignty is still a bigger priority"***

Regardless of the base cause (which we have not attempted to identify during this review) the situation is an example of the need for commissioners and providers to work together more effectively as a system to support each other bring down the cost of local provision to a level that can be afforded within local budgets.



Original statement

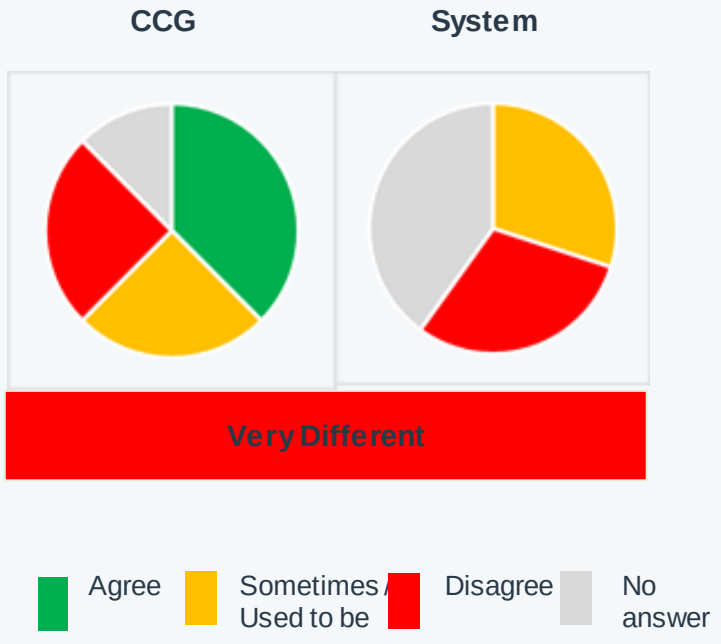
4.4 Discussions on financial planning tend to focus on the "gap" and be short term, rather looking at the whole spend and being long term. The 19/20 Operating Plan has exposed the fragility of the planning capability within the Devon STP.

4.5 Whilst there has been several attempts to define and agree 'place', the concept is still one that introduces some uncertainties across the system

There is a degree of disagreement in the system around the how well defined and understood the definition of "place" is. Whilst the CCG is clear around the design principles that have been set out, it is equally apparent that other partners in the system either don't understand or don't agree with the CCG's approach.

During the final workshop, the CCG established this as one of the top priorities to address and a useful discussion ensued around "what exactly is place?". This identified a number of areas for confusion, which require further exploration. "Place" clearly means different things to different people and the multiple layers (or dimensions) are not sufficiently catered for in the attempt to come up with a "single definition of place".

This confusion is clouding, and potentially slowing, the work that can be done at the different layers. As this has been identified as an immediate priority, system leaders need to come together to revisit the issue and achieve consensus to avoid it becoming an unnecessary distraction.



Original statement (CCG workshop)
4.5. There is emerging consensus around likely number and broad geography for "places", but there is not final agreement yet on whether this is PCN, LA, Acute flow, community service, mental health based or something else.

Revised statement (System workshop)
4.5 There is clear consensus around likely number and geography for "places".

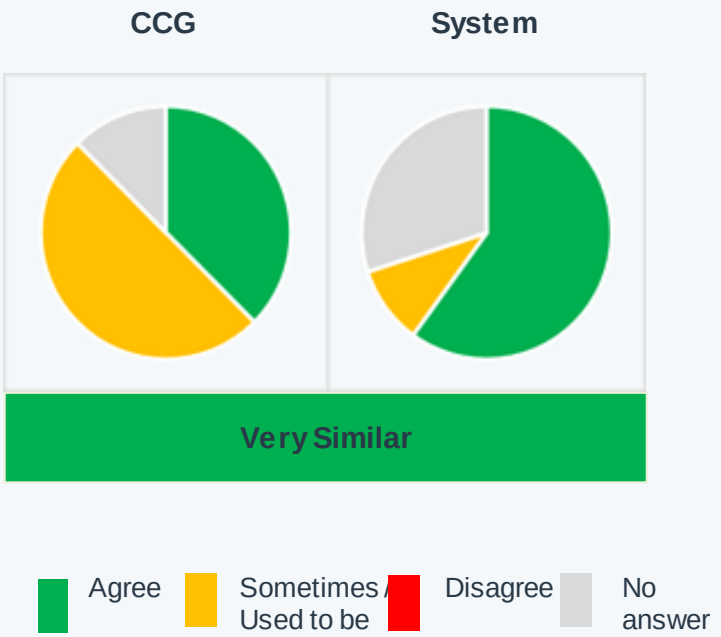
4.6 Local care organisations/ partnerships are on the verge of becoming a reality in parts of the county

The move away from PbR based contracts has enabled the local system to remove the transactional barriers that can impede a system's ability to transform and drive collective improvements. However, some leaders questioned whether, in moving to block contracts, the system genuinely took the opportunity to transform or simply transferred the risk and pressure from providers to commissioners, without achieving any significant transformation. One provider chief executive noted that the providers had used their efficiency gains to consume demand growth and therefore could not deliver their own cost improvement plans effectively.

The removal of these transactional activities has led to the need for a very different role for the CCG and many felt this needed to be reflect more clearly in the way the system operating model plays out. With there being a greater impetus on providers to redesign care models within their fixed funding envelopes, there is the potential for the transfer of CCG capabilities (and resources) to providers to give them the capacity to fulfil these duties more effectively.

This is something that could be explored as part of the Integrated Care Provider procurement process in Plymouth and West Devon.

There are good examples of new commissioning models, such as the delegated responsibilities to the mental health provider for commissioning specialist tertiary services, out of area placements and some voluntary sector services. The potential for these approaches should be explored across a wider service portfolio.



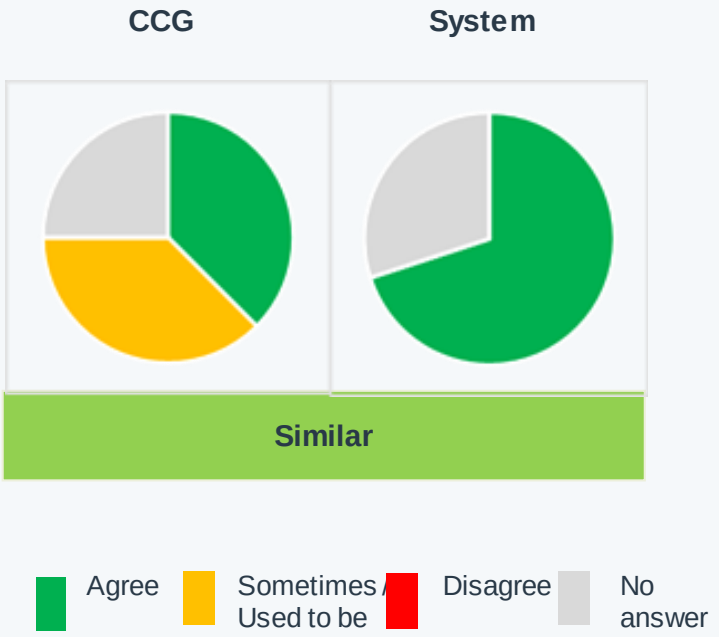
Original statement

4.6 The CCG and the system has already removed many of the commissioner-provider transactional activities and could go further by transferring more operational commissioning and capacity from CCG to LCO/ Ps.

4.7 STP/ ICS governance and leadership needs to pervade all layers of the system, it is not just an executive team issue

During 1:1 discussions and in the workshops, there was recognition that the governance and leadership structures to facilitate effective integrated care working have to pervade all layers of the system. The issue is recognised as being more complex than just the top tier leadership structure at the CEO level of STP partners.

Due to the newness of the PCN structures, there is significant work to do to align PCNs with the next (or 2nd) layer of "place". There is also work needed to define and resource the leadership and governance structures for the 2nd layer of place. As these structures emerge and develop, leaders agree that these can work with the upper "strategic" tier of system working to provide an effective governance structure for the next way of working.



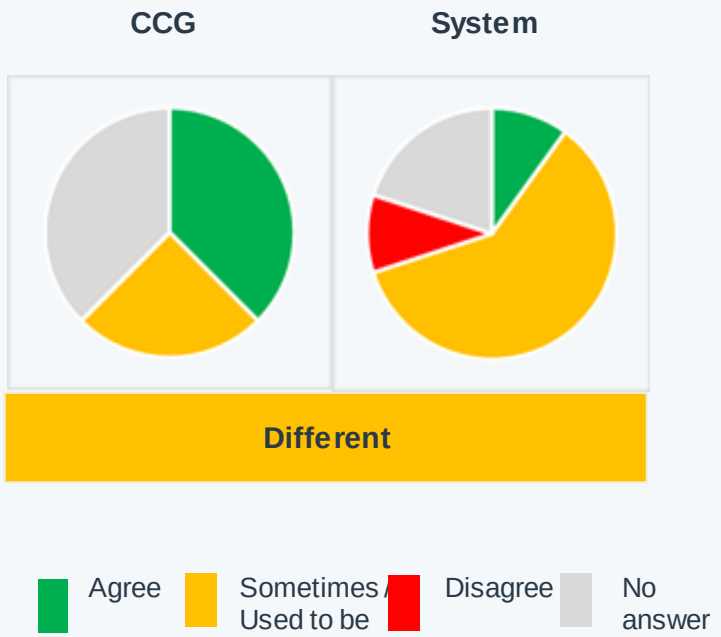
Original statement

4.7 The STP governance structure has the potential to be developed into an ICS ready board but membership will need to be renewed, particularly with greater input from PCNs.

4.8 Clinical care and patient focus needs to become a more prevalent driver during ICS discussions, rather than structures and management

We did not observe many discussions in the range of meetings that we attended around the development of integrated care systems. Most discussions were focused on the "here and now" issues of the financial challenge or the need for improvement in the key areas of concern – RTT 52 week waits, A&E performance, Dementia diagnosis rates, and Cancer 62 day performance.

During 1:1 discussions some staff expressed concern that when ICS discussions do take place, they have a tendency to focus on the management and structural issues rather than the clinical case or the patient benefits. However, when this was played back to people in the workshops the predominant view was that this was only a partial concern, with many quoting examples of the clinical discussions and patient focused discussions being the primary driver in many lower level system meetings.



Original statement

4.8 There is insufficient focus on clinical and patient care in ICS discussions. The case for change has not been clearly articulated and where it is understood it tends to focus on "managerial" rather than clinical issues.

4.9 Middle management and delivery capacity in the STP needs to be manufactured from within existing resources by making it part of the day job, not a bolt-on

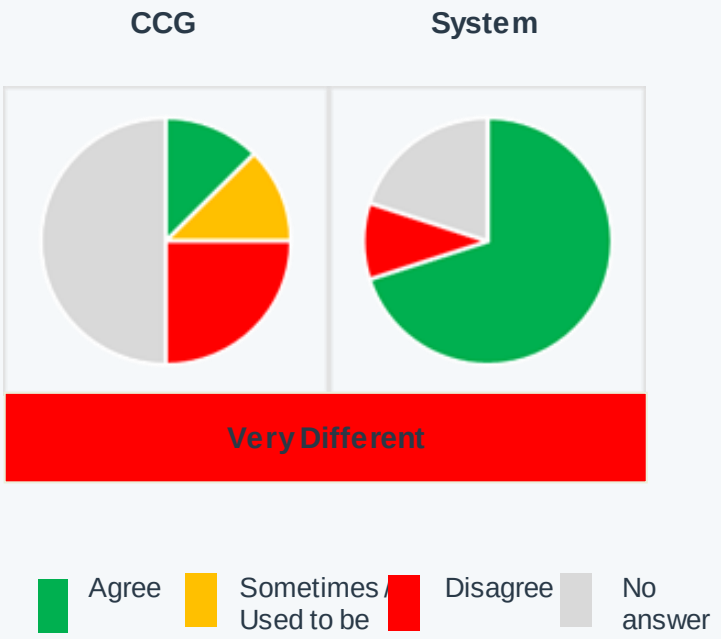
There were very different views expressed about how effectively the STP was resourced at the middle management level. From the wider system perspective there was agreement that structures and resourcing at the upper leadership (ie CEO level) was clear and understood and that there was a PMO in place to monitor and report progress. However, many system leaders cited a lack of dedicated middle management capacity to actually lead and drive initiatives forward on the ground.

One provider chief executive cited an example where the STP had provided funding which enabled a senior nurse's time to be backfilled and released to focus dedicated time on an STP project. However, it was stated that without this funding the person could not have been released.

This presents an interesting case study for system leaders to explore – *the extent to which STP work is seen as "not being the day job"* - and what work can be undertaken collectively to align the STP work differently so it is seen as the day job.

It also raises the issue on the extent to which individual partners in the system recognise the collective responsibility to create the capacity from within their own organisations to invest in system priorities, rather than seeking external funding to enable it.

The former suggests that system priorities take second place to organisational priorities, a situation that will need to be realigned in the absence of additional funding to invest in system priorities given the local financial challenges.



Original statement

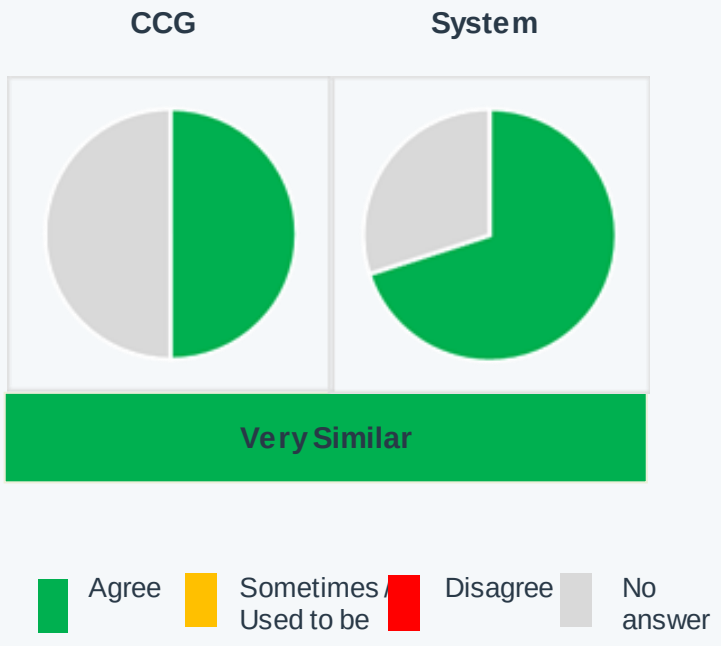
4.9 At system level there is a significant capacity gap in the middle "doing" level. There is leadership to deliver direction and a PMO/ monitoring/ support function to coordinate things. However dedicated resource to develop, lead and deliver changes on the ground is very limited.

4.10 The potential for regulatory devolvement is attractive to system leaders, but not yet

There was clear local consensus that the system needs to move to a position where it can take on more regulatory functions as part of becoming a more strategic facilitator of local care partnerships. Nobody in either workshop disagreed with this ambition, but the fact that half of the CCG staff involved and more than a quarter of the system staff involved in the workshop did not address this issue at all in their review of statements shows that this is not an immediate priority.

This is likely to arise from the fact that most system leaders recognise that there are many other more pressing local priorities to tackle before the system is ready to move to this type of operating model.

Following on from delegated Primary Care Funding to the CCG, the next natural evolution would be to look at opportunities for delegated SpecCom funding as well, although this particular issue was not discussed in the workshops.



Original statement

4.10 Some regulatory functions need to be devolved to the system-level; through a process of 'earned autonomy'.

4.11 Strategic commissioning needs to be considered as much more than just a Devon issue, county borders cannot be the defining boundaries

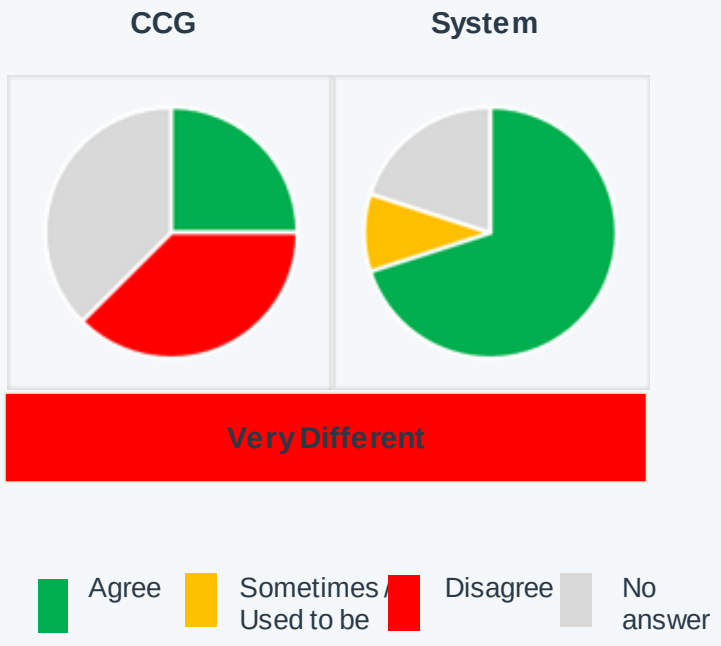
Common themes arose during a number of interviews with staff both within and beyond the Devon system, from commissioners and providers These were based on the following themes:

1. The relationship between University Plymouth Hospital Trust and the East Cornwall population in terms of acute flows.
2. The potential to commission and provide specialist services more strategically given that the relatively small population footprint in Cornwall.
3. The issues around restricting the definition of "place" to existing local authority/ CCG boundaries, which did not fully reflect the commissioning and provision of services on the ground.

During the CCG workshop staff felt that this issue had not been discussed in any significant way and therefore staff were minded to disagree with the statement. However, during the discussion it became apparent that there was potential for this and if the discussions were about strategic "relationships" rather than a "function" then people would be minded to agree with the statement.

Subsequently for the second workshop the statement wording was revised and almost three quarters of the respondents agreed with it.

One GP cited a case where there were significant difficulties in securing community nursing support for an end of life patient who lived in Cornwall but was registered with a Devon GP. This led to a discussion about the need to have an approach to ***"commissioning without boundaries".***



Original statement (CCG workshop)
4.11 There is a recognition and appetite on both sides of the Tamar to build a strategic commissioning function across Devon and Cornwall as part of any future ICS design.

Revised statement (System workshop)
4.11 There is potential for the development of more formal strategic commissioning relationships across Devon and Cornwall as part of any future ICS design.

07

Priority Planning – Project Charters and Delivery Plans

Introduction

The following pages capture the discussion that took place in workshop 2 on 17th May 2019.

The documents are incomplete here, because these slides reflect where the teams got to on the day.

It is important that these priority planning exercises are not simply confined to history now that the workshop is complete. CCG Executives need to take ownership of them, develop them further, engage with their colleagues in the system and use them as the basis for future improvement.

In particular the delivery plans need to be completed and action against them needs to be monitored.

We recommend that the CCG AO ensures that they are reviewed each week as part of the Executive Team agenda to ensure that this is achieved.

Difficult Conversations

Problem Definition

- There is a lack of clarity on what the top two or three priorities are, these are not openly discussed and therefore there is no consensus on the actions that need to be taken.
- Negotiations do happen to build consensus before key meetings (e.g. PDEG) however there isn't enough sharing of perspectives, incentives or targets to get to position that can be agreed on – this is due to a lack of trust.

Proposed Solutions

- Credible, supportive and authoritative system leadership
- Clear and understood small numbers of priorities
- Succinct and clear SMART actions which should force the difficult conversations
- Building consensus before reaching a decision
- Mutual, collective and consistent support

Difficult Conversations

Defined Benefits

- Improved outcomes
- System autonomy
- Ability to innovate
- Improved morale and reputation
- Better decision making (being able to make decisions and faster and more enduring decisions and actions)

Anticipated Challenges

- Resistance to move away from status quo
- Sovereignty trumps system
- Capacity – lack of time, preparation or forming a clear understanding
- Power of veto is too easy
- Sheer scale of challenge
- We are in a lose-lose system, how do we reframe to 'people at the centre'?

Difficult Conversations – Delivery Plan

Action	Owner	Deadline
Develop the 'Stronger Together' narrative		
• Work on building trust by sharing perspectives and findings		
Role-model transparency, e.g. share QIPP/CIP plans		
• Have a number of difficult conversations: 1. Risk share for system 2. Fair Shares 3. Tertiary Services 4. Agree business cases and have discussion about funding 5. Elective delivery system 6. Rationing of care 7. Do we need commissioners? 8. Should the STP SRO 'manage' the provider CEOs? 9. Organisational efficiencies 10. Sharing and adopting best practice		1. 23rd May 2019 2. End of June 3. During PCSS process
Define (and test) organisational constraints – 'red lines'		
Development sessions for PDEG – rebuild formal and informal relationships in order to have facilitated difficult conversations		

Decision Making

Problem Definition

- Lack of clarity on what has been decided
- Lack of ownership of decisions
- Lack of clarity on decision making powers
- Decisions not communicated and followed up

Proposed Solutions

- A development programme for system leaders, inclu. collective decision making
- Refresh and review MOU and TOR for key groups
- Mobility of leaders between organisations
- Develop a role to ensure forward planning for PDEG
- Development of good meeting etiquette – quality of papers, timely, clear purpose
- Align to decision making to understand the planning cycle
- Engagement plan with staff about system working

Decision Making

Defined Benefits

- Ownership and implementation of decisions
- Stronger relationships – more trust
- Clarity of where/when decisions can be made and more timely decisions.
- Greater accountability
- More effective meetings/time management of senior leaders
- Aligned policy/resource/planning cycle
- Key priorities are achieved

Anticipated Challenges

- Funding for a development programme
- Timing – people's availability
- Commitment – buy-in and ownership
- Very low awareness of 'system' more than a few layers down
- Risk of developing a separate governance arrangement for 'system'

Decision Making – Delivery Plan

Action	Owner	Deadline
Commission the development programme for system leaders	? Liz Davenport	Start delivery in July
Refresh and review MOU and TOR for key groups (Collaborative Board, PDEG etc)	Ginny Snaith	By end of June
Develop an approach to move leaders between organisations		
Define a 'business manager' role for PDEG Identify who can perform this role		
Develop a programme of good meeting practice development – e.g. how to write a good board paper, how to present, when papers should go to boards, pre-work required		
Align decision making to planning cycles of organisations		
Develop a communications and engagement plan for staff about system working		

Crisis Working

Problem Definition

- There is a reactive / crisis-driven approach/culture
- We don't have a long-term plan and so we plan year-to-year, bumbling along
- There is no credible narrative to return the system to financial balance and deliver constitutional standards

Proposed Solutions

- Develop an agreed system Long Term Plan and Peninsular Clinical Services Review, with real Local Authority engagement, that defines future operational plans [for each year and at organisation-level]
- Once completed, stick to the Long Term Plan and don't be tempted to redo it
- Create [separate and protected] time for dealing with immediate and long-term issues

Crisis Working

Defined Benefits

- Meaningful plan for public, patients and staff
- Credibility with regulators allows autonomy to get on and deliver
- Enables a common / shared vision for all stakeholders
- Better outcomes and equality of outcomes and access to services
- More stable way of working
- Get out of crisis management mode
- Better [staff] morale
- Devon is a more attractive place to work
- Helps recruit and retain staff

Anticipated Challenges

(Perceived) lack of empowerment in middle tier of management for new ideas / innovations

- Delivering a consistent and coherent plan across Devon, given the problems of identifying place
- Managing business-as-usual and developing the Long Term Plan at the same time
- Aligning the Long Term Plan to the Peninsular Clinical Services Strategy
- Keeping out nerve and not changing direction – being resilient'

Crisis Working– Delivery Plan

Action	Owner	Deadline
Coordinate the writing of the system Long Term Plan	Penny Harris	
• Reset PDEG in line with already defined purpose: 1. Ensure agendas are in line with purpose 2. STP programme directors to liaise with their CEO sponsor to ensure PDEG gets the right stuff 3. STP team to define for programmes what PDEG updates should look like– Continuous activity planning, not just a 'plan [and forget'	STP Directors	

Priorities and Resourcing

Problem Definition

- Priorities are not clear or well understood. It is not clear what it means to say something is a priority.
- Therefore, they are not owned across the system
- Therefore, people do not have clear delivery responsibilities
- Therefore, people cannot be effectively held to account for delivery
- And it is not clear how priorities should be properly resourced [at system-, place- and neighbourhood-levels]
- There is a lack of a clear link between input effort and required contribution to improving system performance (financial and other)
- Planned Care and Urgent Care (ICM) have different challenges on engagement and delivery

Proposed Solutions

1. Clearly defined priorities that are outcome-based
2. Agree areas to de-prioritise
3. Agree how to resource each priorities
4. Clear deliverables, with timelines and impacts
5. Ensure all people are clear on who is responsible for change management and who is responsible for benefits management
6. Improved links from programmes to deliverables
7. Agree how 5+2 STP priorities need to link to each other and where they cross over
8. Articulate the current STP resources and agree ways to strengthen the STP infrastructure to deliver the priorities, i.e. dedicated STP capacity plus dedicated support from stakeholders

Priorities and Resourcing

Defined Benefits

- Clearer narrative on transformation plans (easier to build on in Long Term Plan draft)
- Improved financial situation for system
- Improved performance in system, defined by deliverables
- Improved patient experience and outcomes
- Better job satisfaction for staff and effective system relationships
- More time for strategic conversations / planning
- Assurance inside and outside (NHSE / I, plus OSC) of system on delivery
- Citizens feel heard because they are influencing and shaping priorities

Anticipated Challenges

- People are feeling that delivering change (transformation) will equate to loss of money / income [for their organisation]
- There are differing organisational priorities
- There are massive and / or unclear cost improvement plans
- System is not just the sum of its individual organisations
- There is too much (re)analysis
- Need appropriately skilled workforce to deliver the change
- Therefore, either need to recruit or redesign workforce, but both a problematical

Priorities and Resourcing – Delivery Plan

Action	Owner	Deadline
Defined programme roles: CEO sponsor, SRO, linked CFO		
Who are the right people to lead and who needs to follow / do		
Ensure people are clear on their responsibilities		
Obtain system ownership of the plan through sign-off at PDEG, and through [statutory] organisations, LCPs, and PCNs		
Resources committed form all stakeholders		
Agree targeted population involvement		

Defining Place

Problem Definition

- We need to agree how we best work together to support places to organise services for people.
- We need to agree how we define place to organise services for people and then we must implement and organise.
- Place depends on purpose

Proposed Solutions

- 1 system
- 3 pooled funds
- 4 acute/community footprints
- 31 PCNS
- 51 towns and villages
- Agree and resource LCPs, built around PCNs
- Financial analysis to make progress on pooled budgets
- Define and communicate LCPs
- Commissioning without boundaries.
- Delivering without boundaries

Defining Place

Defined Benefits

- Reducing duplications, better efficiencies
- One set of conversations with population
- Joined up services with less hand-offs
- Identifying issues earlier, supporting upstream intervention.
- Removing barriers to change, threats of ceding power, sovereignty and control, change in practice
- Give clarity of purpose to improve speed of implementation of ICS

Anticipated Challenges

- Understanding the implications of defining place
- Perceived threats
- Place means something different to everyone so how can we meaningfully define it?
- How can we move past the above challenge?

Priorities and Resourcing – Delivery Plan

Action	Owner	Deadline
Create a communique (including a picture or visual / video) that enables all to have a shared understanding.	Comms	End of Q2
Create a comms/stakeholder engagement plan and take through system group for “reminder”	Comms	
Needs clear purpose of what place does.		

Focus on patients and clinical care

Problem Definition

- We don't have sufficient focus on individuals or population needs.
- What will we do differently in response to what people tell us?
- System currently fails to address inequalities of access and outcome.

Proposed Solutions

- Single system framework to create the environment for a new social movement.
- To do this we will:
- Facilitate Parish, Town and District approach
- Mass engagement / people's movement
- Crowd funding
- Recognise different types of community
- Engage with our workforce

Defining Place

Defined Benefits

- People feel involved / heard / able to shape
- People understand constraints
- People feel responsible for their own health and care and each other's lives
- Fewer people need statutory services
- People are healthier
- Services are more aligned to people's priorities

Anticipated Challenges

- We are measured by process measures vs outcomes → not conducive to change in behaviour
- Some people may say that there is no evidence base
- Hard to reach groups

Priorities and Resourcing – Delivery Plan

Action	Owner	Deadline
Identify a lead to mobilise this approach	Paul Giblin [Jenny Stephens to advise]	
Allow development of self organising teams		
Leaders to “get out of the way”		

08

Further recommendations

Recommendations

These are recommendations that do not naturally emerge from the discussions that will be required in response to each KLoE

KLoE 1:

- Instigate a development programme for system leaders, to include difficult conversations and sessions to facilitate these.
- Recruit a Transformation Director for the STP to drive change programmes.
- Develop change management and quality improvement skills across the STP, to drive and embed improvement.
- Work on meeting disciplines, e.g. forward planning and developing agendas, writing good papers, sending out papers in advance etc
- Instigate a strategic workforce planning and talent management programme across the STP, align to workforce strategy.

KLoE 2:

- Review and redesign the recruitment process for senior leaders.
- Develop a first 100 days programme for new leaders in the system.
- Develop a joint leadership and team development programme for the CCG Senior Leadership Team with other key parts of the system, i.e LAs and providers.
- Get clarity on the purpose of the CCG and the key roles and responsibilities
- Work to embed CCG values needs to ensure it aligns with the wider system values – a piece of strategic workforce planning across the system can add value.

KLoE 3:

- Develop the triumvirate model of leadership

KLoE 4/ 5:

- Protect a team/ develop an incubator to focus on developing innovative long-term initiatives (ensuring they do not get pulled back into solving today's problems)

Project Charters

- Ensure they are completed, shared and used as a basis for developing solutions to the prioritised actions

Other issues

The following themes should be explored in more detail as part of the next phase of system development:

- Agreed Devon health outcomes framework
- Health Information Exchange
- Analytics – risk stratification and impact
- Workforce modelling and planning
- Shared training & education (building on talent management
- System stakeholder engagement and communications.

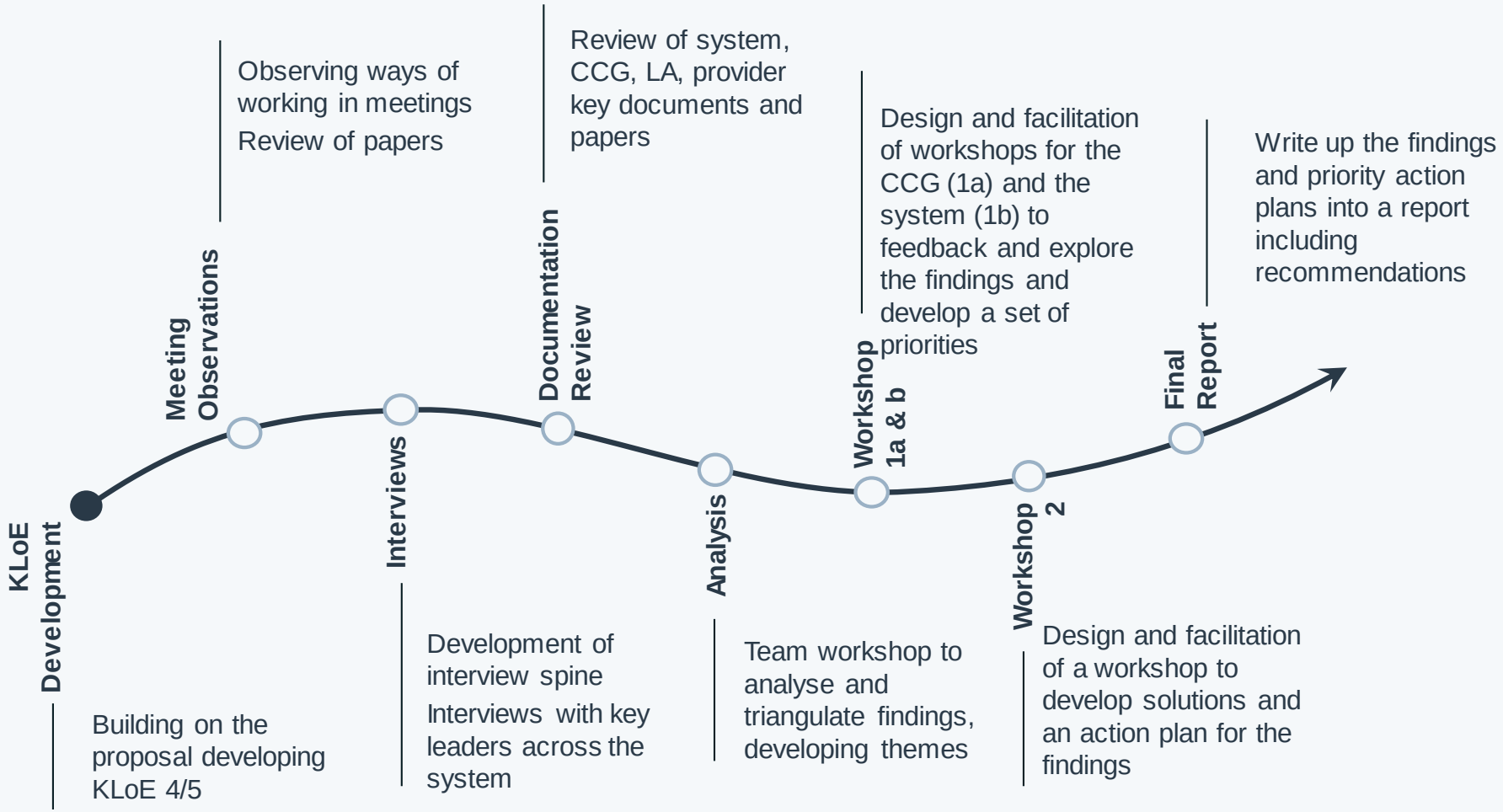
09

Appendices:

1. Our approach
2. Key lines of enquiry
3. Semi-structured interview spine
4. Number and list of interviewees
5. Meetings observed
6. List of documentation
7. Bibliography

Our Approach

PA's approach to conducting the review was based on our experience of successfully supporting other health and social care systems to deliver similar reviews. Following a start-up period, we moved into a data collection phase, followed by an analysis phase, then concluding with a sharing of findings and coproduction of an action plan.



Summary of Key Lines of Enquiry (KLoEs)

The original terms of reference for the review established three key lines of enquiry (KLoEs).

1. Behaviours and ways of working that support the sustainable development of an integrated care system in Devon.
2. CCG leadership capacity and capability that supports effective commissioning across the Devon system.
3. The right senior system leadership roles to support effective collaboration and partnership working.

To these three, PA advised adding a further two KLoEs, for wider context, which were later combined.

4. Building towards Devon becoming a fully-authorised and sustainable integrated care system
5. Defining the Devon health and care system at system-, place-, and locality-levels, and in relation to its external partners/neighbouring systems

KLoE 1: Behaviours and ways of working that support the sustainable development of an integrated care system in Devon, 1/2

1.1 How would you describe the behaviours and ways of working across the Devon Health and Social Care System?	• What are the strengths? • What works less well? • What would patients/service users say? • What do staff say?
1.2 What style(s) of leadership (and followership) do the senior leaders within the system display?	• Having the ability to step back and develop a shared purpose and vision • Able to operate in a VUCA environment • Influence without line management authority and collaborate with key stakeholders • Surface and resolve conflicts; demonstrate greater openness; and behave altruistically towards each other • Having frequent personal contact • Personal qualities and skills of: patience, persistence, flexibility and resilience
1.3 How well do system leaders ensure their organisations take a 'whole system' approach to leading and supporting change?	• Are STP/ICS priorities clearly evident in individual organisation plans and is collaborative partnership working an embedded part of the 'way the system works'? • Do organisational leadership teams promote and develop strong relationships with their STP/ICS partners? • Do system leaders proactively think about the opportunities and risks of working with partners when developing and delivering plans?

KLoE 1: Behaviours and ways of working that support the sustainable development of an integrated care system in Devon, 2/2

1.4 How well to the existing STP/ICS governance structures function? And do they promote and model the necessary ways of working?	• Do PDEG and Collaborative Board function effectively? • Is the relationship between the system and the regulators clearly understood? • What developments are required between regulators and the system to enable successful progression to ICS status?
1.5 Where challenges do arise, both within and between organisations? How do these get resolved?	• How do leaders of individual organisations balance their statutory duties with the responsibilities they have as system partners? • How do they ensure this is effectively cascaded through their organisation?
1.6 What are the challenges and development requirements to achieve greater integration?	• What might get in the way?

KLoE 2: CCG leadership capacity and capability that supports effective commissioning across the Devon system, 1/2

2.1 Does the CCG have the right leadership capacity, capability and structure?	• Does the CCG have a clear vision and a credible strategy and plans to deliver the NHS LTP and STP/ICS priorities? • Can the Accountable Officer, perform their statutory duties and – in addition - adapt to their future role as a single healthcare strategic commissioner within an ICS? • Is there clear accountability at system-, place- and locality-levels?
2.2 Do the CCGs have appropriate mechanisms for ensuring the Chairs and Governing Body members have sufficient capacity and capability to undertake their roles?	• Does the Governing Body and its committees receive robust and appropriate information, with effective systems for data monitoring and analysis to support decision-making and action? • Does the Governing Body function effectively as a team? • Are appropriate support, training and development opportunities available for Governing Body members?
2.3 Does the leadership of the CCGs engage effectively with their membership practices?	• Are there plans in place to recruit, appoint and then induct and support PCN clinical directors? • Does the CCG support interaction between PCNs and other providers? • What lessons can be learnt from recent examples in Devon and other CCGs?

KLoE 2: CCG leadership capacity and capability that supports effective commissioning across the Devon system, 2/2

2.4 Is there a clear vision, blueprint and roadmap for how the merged CCG will integrate with the different levels of the ICS?	• Do leaders understand the challenges involved (in developing an ICS) and can they identify the actions needed to address them? • How – over time - might some functions be shared or transferred to providers and/or local authority partners?
2.5 Do leaders have the skills, knowledge, experience and integrity that is required?	• Do they role-model the new CCG values? • Do they create a sense of shared purpose? • Do they create the environment that enables people to do their jobs effectively? • How do you think CCG leaders are perceived by others system partners?
2.6 Is Devon CCG a 'learning organisation'?	• Does the CCG make effective use of internal and external reviews? • Is there a focus on talent management: identifying and developing current and future clinical and managerial leaders? • What (further) development do you think CCG leaders to encourage a learning culture?

KLoE 3: The right senior system leadership roles to support effective collaboration and partnership working

3.1 What are the leadership requirements of the ICS and how is this best expressed in terms of formal roles?	• Does the current infrastructure of the system provide sufficient capacity and capability to support a single system Chair and Chief Executive? • Do these roles need to be supported by a wider team? • Devon has operated two different STP leadership team models – what can be learnt from this? • What are the different leadership requirement at system, place and locality?
3.2 What is the expectation of the role of system Chair?	• This role has become a national policy requirement – how should it be interpreted locally? • Devon has now had two system Chairs – what can be learnt from this? • Is the role currently appropriately supported?
3.3 What is the expectation of the role of Chief Executive of the System?	• Is it appropriate to combine this role with the CCG Accountable Officer role as the executive leader of the ICS? • What should the role of CCG Accountable Officer focus on? • Is it preferable for the System Chief Executive to has a provider background?
3.4 What alternative models should be considered?	• What other models are there and what are their merits? • What is the future role of the Health and Wellbeing Boards?

KLoE 4: Building towards Devon becoming a fully-authorised and sustainable integrated care system, 1/2

4.1 Is the Devon H&SC System in a position to meet the NHSE/I tests for ICS authorisation?	• Effective leadership and relationship capacity and capability • Track record of delivery • Strong financial management • Focused on care redesign • Coherent and defined population(s)
4.2 Does the Devon H&SC System have in place the requirements for and ICS in the NHS Long Term Plan?	• A partnership board, drawn from and representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate - local authorities, the voluntary and community sector and other partners • A non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/ governing bodies • Sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes • Full engagement with primary care, including through a named accountable Clinical Director of each primary care network

KLoE 4: Building towards Devon becoming a fully-authorised and sustainable integrated care system, 2/2

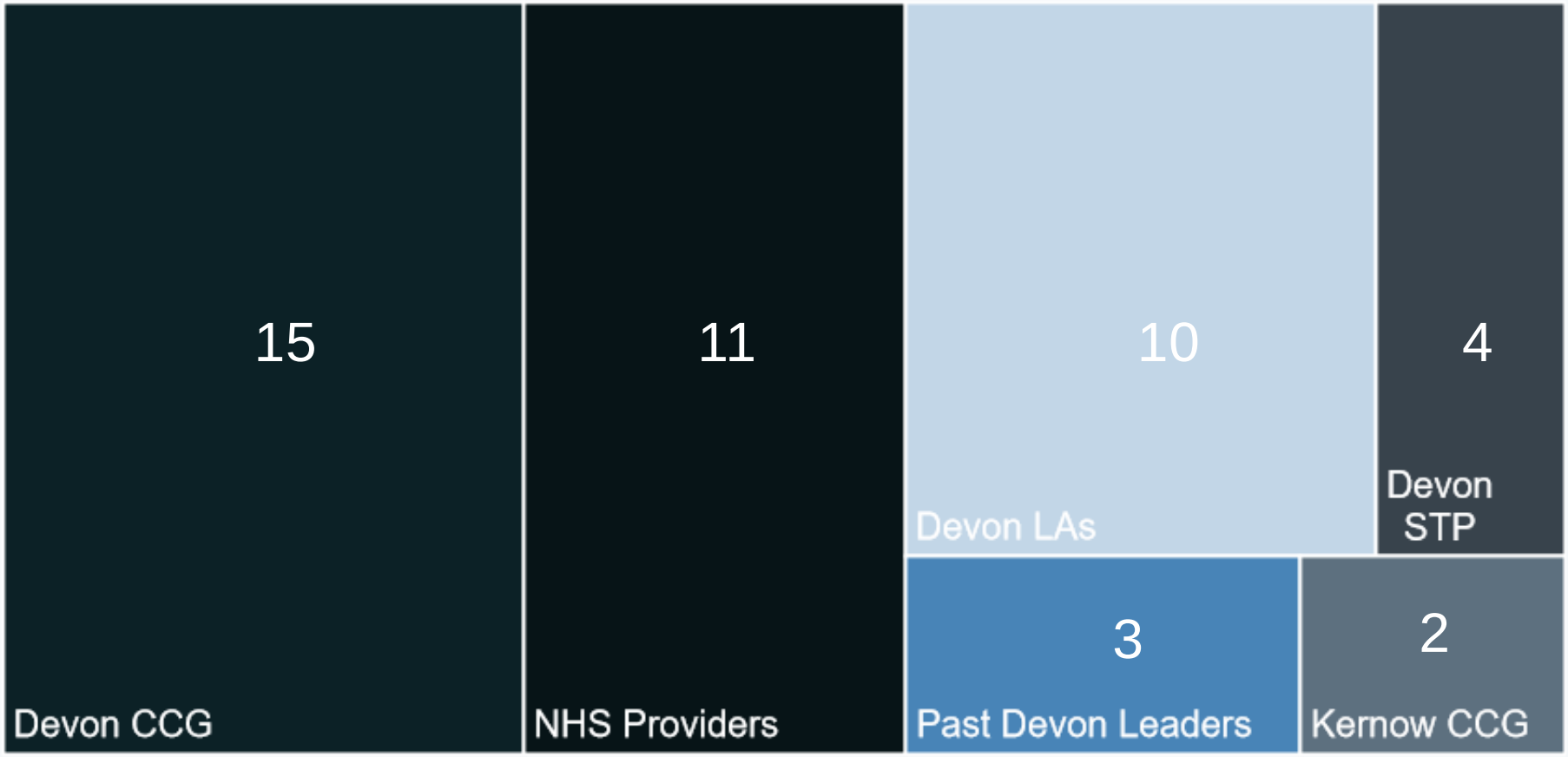
4.3 Is the Devon H&SC System adequately prepared for any new system-orientated regulation and inspection regime?	• A greater emphasis by the Care Quality Commission (CQC) on partnership working and system-wide quality in its regulatory activity, so that providers are held to account for what they are doing to improve quality across their local area; • All providers within an ICS will be required to contribute to ICS goals and performance, backed up by a) potential new licence conditions (subject to consultation) supporting NHS providers to take responsibility, with system partners, for wider objectives in relation to use of NHS resources and population health; and b) longer-term NHS contracts with all providers, that include clear requirements to collaborate in support of system objectives; • Clinical leadership aligned around ICSs to create clear accountability to the ICS. Cancer Alliances will be made coterminous with one or more ICS, as will Clinical Senates and other clinical advisory bodies. ICSs and Health and Wellbeing Boards will also work closely together

KLoE 5: Defining the Devon health and care system at system-, place-, and locality-levels, and in relation to its external partners/neighbouring systems

5.1 What is preferred model for the Devon H&SC System structure?	• What functions will be performed at system-, place- and localities-levels? • How well developed are the current capabilities and capacities at each level? • How will 'cross-board' issues be managed, eg Cornwall-West Devon or Ambulance commissioning with Dorset?
5.2 Are the risks to patient outcomes and financial performance of delivering services across larger populations well understood and effectively mitigated?	• Will it be clear to public, patients, staff and other stakeholders where accountability for performance and spending sits within the system? • Who – individual, group or organisation – is recognised as the system leader? • Will there be financial risk-sharing mechanisms in place to meet a System Control Total?
5.3 What kinds of public, patient and clinical input are envisaged at each level of the system?	• How effective is the STP Clinical Cabinet? • How will clinicians at place-level operationally collaborate across organisational boundaries? • How influential will PCN Clinical Directors be at locality-level? • How will public and patients be able to influence strategic and operational decision-making?

High-level breakdown of interviews

We conducted 45 interviews with key leaders across health and social care in both the Devon and Cornwall systems. The participants and roles from each organisation are listed below.



Interviews – NHS Devon CCG

Organisation	Name	Role
NHS Devon CCG	Dr Paul Johnson	Chair
NHS Devon CCG	Simon Tapley	Interim Accountable Officer
NHS Devon CCG	John Dowell	Chief Finance Officer
NHS Devon CCG	Lorna Collingwood-Burke	Chief Nursing Officer
NHS Devon CCG	Sonja Manton	Interim Director of Commissioning
NHS Devon CCG	Jo Turl	Director of Transformation
NHS Devon CCG	Andrew Millward	Director of Communications and HR
NHS Devon CCG	Dr John Womersley	Chair Northern Locality
NHS Devon CCG	Dr Shelagh McCormick	Chair Western Locality
NHS Devon CCG	Dr Simon Kerr	Chair Eastern Locality
NHS Devon CCG	Dr David Greenwell	Joint South Locality Chair
NHS Devon CCG	Dr Mat Fox	Joint South Locality Chair
NHS Devon CCG	Nick Ball	Lay Member Governance and Probity
NHS Devon CCG	Dr Nick Kennedy	Lay Member Secondary Care

Interviews – Local Authorities

Organisation	Name	Role
Devon County Council	Phil Norrey	CEO
Devon County Council	Jennie Stephens	Chief Officer for Adult Care and Health
Devon County Council	Dr Virginia Pearson	Director of Public Health
Devon County Council	Jo Ollson	Director of Childrens' Services
Torbay Council	Steve Parrock	CEO
Torbay Council	Caroline Taylor	Director of Adult Services and Housing
Torbay Council	Dr Caroline Dimond	Director of Public Health
Plymouth City Council	Tracey Lee	CEO
Plymouth City Council	Craig McArdle	Strategic Director for People
Plymouth City Council	Ruth Harrell	Director of Public Health

Interviews – Health and Social Care Providers

Organisation	Name	Role
Torbay and South Devon NHS FT	Liz Davenport	CEO
Torbay and South Devon NHS FT	Richard Ibbotson	Chair
The Royal Devon and Exeter NHS FT Northern Devon NHS Trust	Suzanne Tracey	CEO
The Royal Devon and Exeter NHS FT	James Brent	Chair
The Royal Devon and Exeter NHS FT	Chris Tidman	Director of Finance
University Hospitals Plymouth NHS Trust	Ann James	CEO
University Hospitals Plymouth NHS Trust	Richard Crompton	Chair
Devon Partnership NHS Trust	Julie Dent	Chair
Devon Partnership NHS Trust	Melanie Walker	CEO
Livewell Southwest CiC	Duncan Currall	Chair
Livewell Southwest CiC	Adam Morris	CEO

Interviews – Other

Organisation	Name	Role
NHS NEW Devon CCG	Dr Tim Burke	Chair
STP	Dame Suzi Leather	STP Independent Chair
STP	Dr Rob Dyer	STP Clinical Director
STP	Warwick Heale	STP Programme Director
STP	Mairead MacAlinden	Peninsular Clinical Services Strategy Programme Director
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
Kernow CCG	Jackie Pendleton	Chief Officer
Kernow CCG	Ian Chorlton	Chair
NHS E/I	Mark Cooke	Director of Strategy and Transformation

Meetings

We attended 19 meetings…A list of the meetings we attended are shown below

Meeting	Dates Attended
CCG Executives	2 April; 9 April; 16 April; 23 April
CCG Executives / STP Directors	2 April; 9 April; 16 April
CCG Senior Leadership Team Meeting	9 April; 14 May
CCG Quality Committee	11 April
STP Performance Group	12 April
Devon Health and Wellbeing Board	11 April
CCG Governing Body	25 April, 23 May
CCG Finance Committee	18 April
STP Finance Group	18 April
North Devon Locality Meeting	1 May
STP Clinical Cabinet	9 May
Integrated Commissioning Executive	15 May

Documentation - we reviewed the following documents and meeting papers

CCG Papers	STP Papers	Local Authority Papers	Provider Papers
• Board Assurance Framework • Operating Plan Submission • Governing Body papers • Internal audit • Merged CCG constitution • Quality Committee • Success regime • Stakeholder survey • Staff survey	• The STP Plan • Collaborative Board papers • PDEG papers • STP updates • Memorandum of Understanding • STP 2 Year Report • ICS Readiness documents • Locality Board Papers	• ASC Annual Report • Health, safety and wellbeing annual report	• Trust Board papers

KLoE 1: Behaviours and ways of working that support the sustainable development of an integrated care system in Devon

- Andrew Constable (2015) 'Six challenges to becoming an effective system leader' on The Health Foundation website
- Sally Hulks and co. (2017) *Leading across the health and care system: lessons from experience* The King's Fund
- NHS Leadership Academy (2013) *Healthcare Leadership Model: The Nine Dimensions of Leadership Behaviour*
- Nicholas Timmins (2015) *The practice of system leadership: being comfortable with chaos* The King's Fund
- Peter Senge (2015) 'The dawn of system leadership' in *Stanford Social Innovation Review*
- Social Care Institute for Excellence (2018) *Leadership in integrated care systems: report prepared for the NHS Leadership Academy*

KLoE 2: CCG leadership capacity and capability that supports effective commissioning across the Devon system

- Department of Health (2007) *World Class Commissioning Competencies*
- House of Commons Committee of Public Accounts (2019) *Clinical Commissioning Groups*
- National Audit Office (2018) *A review of the role and costs of clinical commissioning groups*
- NHS England (2018) *CCG Improvement and Assessment Framework 2018/19*
- NHS England (2018) *CCG Improvement and Assessment Framework 2018/19: Technical Annex*
- James Peskett (2016) 'Quantum Leap' on LinkedIn website
- Ruth Robertson (2019) 'Commissioning is dead, long live commissioning' on The King's Fund website

KLoE 3: The right senior system leadership roles to support effective collaboration and partnership working

- Anna Charles and co (2018) *A year of integrated care systems: reviewing the journey so far* The King's Fund
- Chris Ham and co. (2018) *Leading across the health and care system: lessons from experience* The King's Fund
- NHS England (2019) *The NHS Long Term Plan*
- NHS England and NHS Improvement (2019) *NHS Operating Plan and Contracting Guidance 2019/20*

KLoE 4: Building towards Devon becoming a fully-authorised and sustainable integrated care system

- European Innovation Partnership on Active Health and Ageing Action Group (2017) *Maturity Model for Integrated Care*
- NHS Croydon CCG and London Borough of Croydon (2016) *Provider Considerations for Delivering an Outcome Based Contract*
- NHS Improvement and NHS England (2018) 'Report on next steps on the development of Integrated Care Systems' in *Meeting in Common of the Boards of NHS England and NHS Improvement*
- Social Care Institute for Excellence (2017) *Developing an Integration scorecard: a model for understanding and measuring progress towards health and social care integration*
- Social Care Institute for Excellence (2017) 'Logic Model for Integrated Care'

KLoE 5: Defining the Devon health and care system at system-, place-, and locality-levels, and in relation to its external partners/neighbouring systems

- Beccy Baird (2019) 'Primary Care Networks Explained' on The King's Fund website
- BMA (2019) *Integrated Care Systems: What are they, and what do they mean for doctors?*
- BMA (2019) *The Primary Care Network Handbook*
- Sharon Brennan (2019) 'The Integrator: Five questions about ICS development' in *HSJ*
- Anna Charles and co. (2018) *A year of integrated care systems: reviewing the journey so far* The King's Fund
- Jeff Goldsmith (2019) 'What a "health system" is and isn't' in *Harvard Business Review*
- Richard Murray (2019) 'Primary care networks and the NHS Long Term Plan: the new players on the pitch' on The King's Fund website
- NHS England (2018) *Primary Care Networks Reference Guide*

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