

Mapping the
market
Commissioning
support
services

NHS
England

 Cogora

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140 London Wall, London EC2Y 5DN, UK.

Cogora
T +44 (0)20 7214 0500
F +44 (0)20 7214 0501
E enquiries@kogora.com
W www.kogora.com

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Foreword



To meet the unprecedented challenges facing today's NHS we need to develop commissioners who can improve quality now and lead the transformation of services for the future. Professional at-scale commissioning support services (CSSs) will be key to achieving this. This is why NHS England's strategy for developing commissioning support – *Towards Commissioning Excellence: A Strategy for Commissioning Support Services*¹ set as its goal that all commissioners should be able to access excellent affordable support¹.

We have embarked on an ambitious programme to make this a reality by:

- > Supporting commissioners to become informed confident customers of commissioning support, choosing those services which best meet their individual needs
- > Enabling the creation of a diverse cohort of excellent affordable providers of CSSs, drawing on the best of the NHS, commercial and voluntary sectors
- > Establishing simple proportionate mechanisms for procuring CSSs and ensuring service continuity. We propose to co-develop with commissioners and providers a lead provider call-off framework to enable commissioners to secure the best possible services as easily as possible.

Mapping the market charts some of the significant changes which are already taking place as the market for CSSs evolves. There is a tangible sense of momentum and improvement:

- > Commissioning support markets developing enhanced commercial and transformational skills and capacity
- > Recognition of the important contribution (in terms of additional skills and capacity) of the commercial and voluntary sector, and partnering to secure this
- > Active exploration – across the sectors- of approaches to secure the benefits of scale
- > An increasing range of strong offers of transformational support, for example, to roll-out outcome-based commissioning, new innovative business intelligence and analytics products and services
- > Clinical commissioning groups increasingly valuing the contribution of great commissioning support and – rightly – becoming more demanding customers.

If these trends continue I'm optimistic of achieving our goal of creating a vibrant diverse market in commissioning support, enabling great commissioning and – crucially – better outcomes and experience for patients and value for money for tax-payers.

Bob Ricketts

Director of Commissioning Support Services Strategy & Market Development
NHS England

¹ <http://www.england.nhs.uk/2013/06/13/fut-of-comm-supp-serv/>

About this report

Cogora in collaboration with NHS England conducted a series of in-depth interviews with the managing directors of 17 commissioning support units (CSUs) and the health leads at 23 independent sector providers of commissioning support services (CSSs). The aim of this research is to obtain a picture of the commissioning support resources currently available to help clinical commissioning groups (CCGs) navigate this emerging market.

We questioned these leaders about what services they provide, their views on the current challenges and opportunities, and their collaborations with other companies.

The report serves as a comprehensive directory for CCGs to find the right blend of support services for their commissioning needs.

It also provides useful information to the market to see where organisations can form mutually beneficial relationships to support commissioners.

About Cogora

Cogora is a leading, pan-European healthcare publishing and research company. For over 20 years we have enjoyed a first-rate reputation for delivering top quality, timely content that supports healthcare professionals with their clinical decision-making and career development.

Our portfolio of journals and websites includes Nursing in Practice, Management in Practice, The Commissioning Review and Hospital Pharmacy Europe. We deliver 12 national conference exhibitions – including Commissioning Live – each year, as well as more than 100 smaller educational ‘road show’ events across the UK. And we produce numerous ‘roundtable’ discussion meetings, focusing on a single therapeutic area, across Europe.

For more information about this survey or, more broadly, about Cogora, please contact:

Alex Beaumont

General Manager

Cogora

alexbeaumont@Cogora.com

T +44 (0)20 7214 0500

Executive summary

For clinical leaders to really succeed in changing the way healthcare is provided to make it more efficient, higher quality and better for patients they are going to need help.

That help comes in the form of commissioning support services (CSSs) which must be responsive and ready to meet the demand of these clinical commissioning groups (CCGs). In turn CCGs must be clear about what they are looking for whether that's back office or major transformational support.

Although still a relatively nascent market, there have already been significant developments. Commissioning support units (CSUs), hosted by NHS England until 2016 and consisting largely of former primary care trust staff, have already dropped in numbers from 23 to 18, with further mergers predicted by those interviewed in this report.

The independent sector is articulating its offers but at this point the majority see their route to the NHS as through CSUs.

The radical changes that are outlined in the NHS *Call to Action* highlights the need for a competitive and sustainable CSS market. Among the CSS offers, transformational service redesign, business intelligence and data analytics are particularly important.

CSUs are developing and maturing a new approach. While they are developing commercial, transformational and customer experience, they have expert local knowledge about the NHS culture and front line commissioning experience.

CSUs are also making headway in the face of the uncertainty that confronts them in two years' time by expanding their customer base and undertaking innovative approaches to suit customer needs.

The independent sector has its advantages, which includes cross industry commercial experience and long-term investment in infrastructure, knowledge development and resources.

Their commercial experience has given rise to innovative payment models with some organisations offering to put their fees on the line to achieve desired outcomes and others proposing to take responsibility for the risks given that they have a share of the savings derived.

Be it work with CSUs or CCGs, there seems to be a clear consensus among independent sector providers of the need for skills transfer, which in the long-run is very helpful towards providing empowerment.

Although CSUs and independent sector providers are still finding their place in the market, at present, there is an emerging trend of independent sector providers working through CSUs to provide commissioning support rather than working directly with CCGs. This could be attributed to the fact that CSUs are able to work at scale compared to CCGs, some of which are quite small.

A particular concern among independent sector providers

is that the CCGs limitation in size may mean difficulties in effecting change across the whole health economy.

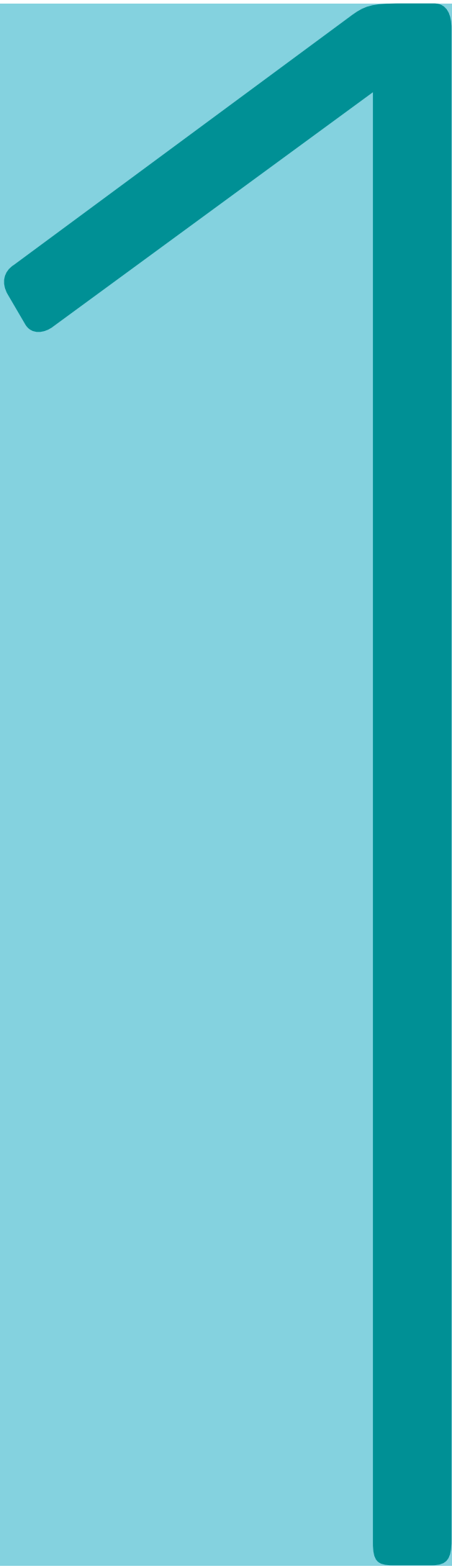
However with CCGs showing an interest in the lead provider framework, which allows both independent sector providers and CSUs to respond to tenders on an equal footing, it remains to be seen how organisations will learn to balance partnering with competing.

With regards to CSUs, there is an increasing trend of providing certain services at scale and a move towards providing more specialised services.

Across the two sectors, there are already clear areas of strength with a variety of networks and alliances formed within and across both CSUs and independent sector providers.

"Big data" capabilities and making use of unstructured data are key areas of focus for both sectors moving forward as CSS organisations strive to coordinate more integrated and joined up care.

This provides a very promising range of offerings for commissioners to mix and blend according to their individual commissioning needs, especially with the voluntary sector set to further deploy their expertise in the market.



Section 1

NHS Commissioning Support Units

Commissioning Support Unit

Managing director: Rachel Pearce

1. What services do you provide?

The full range of commissioning support services (CSSs) – service redesign, contract support, business intelligence, procurement, continuing healthcare (CHC), medicines optimisation, HR, IT, communications and engagement and finance.

2. How are you structured?

We work on a professional services model. We have five senior partners who cover redesign and innovation, procurement and performance, person-centred commissioning, business intelligence and business strategy as well as a managing director, chief financial officer and chief operating officer.

It's a flat structure with four layers – senior partners, associates, leads and business support. We have moved away from a traditional hierarchical structure and the expectation is that staff will be agile within this matrix.

Senior partners are also our relationship managers and a senior level point of contact for the clinical commissioning groups (CCGs).

3. What regional challenges does your CSU face?

Our population is quite elderly so we have service needs for the frail elderly and in preventing hospital admission. There are issues of inequality as the south of the area is very affluent but there are highly deprived areas across the north.

We have significant changes ahead in the acute sector. George Eliot Hospital is looking for a franchise arrangement and University Hospitals Coventry and Warwickshire Trust is aiming to become a foundation trust. There are four acute providers in our area so we need to support clinical commissioners in deciding who will provide the best service for patients.

Our CCG customers did not inherit any debts as all of the primary care trusts (PCTs) balanced their books – but there are challenges around the quality innovation productivity and prevention (QIPP) programme. Some previously affluent health economies are facing an increase in demand on urgent care.

4. What are your strengths and weaknesses?

One of our strengths is that we are a relatively small, agile and creative organisation. We have been able to produce innovative work and we are able to adapt our approach to customer needs. Our strategy is to become an excellent specialist provider of support rather than being as big as possible across a very broad portfolio. We now have an approach to providing commissioning support to other NHS and public sector organisations.

We are strongly collaborative in our approach with other organisations and can demonstrate thought leadership in transforming commissioning and the future skills that are needed. We are doing some really exciting work with the Young Foundation around developing social ventures and enabling the third sector to play a greater role in service provision. We are working with our CCGs to develop a robust support service for quality so that we can respond to the Francis and Berwick reports. We are working nationally and locally to identify how we support CCGs for the next phase of QIPP and the 'Call to Action'.

We have a strong service redesign and transformation team of some 20 skilled staff and an excellent business intelligence product called Ventriss, which provides real time information on hospital performance. We are developing dashboards for primary care

and have a strong procurement and technical offer around contracting.

We have 130 staff working on continuing healthcare which we are providing to all our CCGs – this covers assessment, developing packages of care and carrying out reviews. We have, and continue to see, significant growth in this area. We are also looking at a radical model for future CHC support which maximises productivity and ensures high quality clinical advice and procurement.

We are still a new organisation and we are embedded in NHS England, so we will need to work under its limitations while maximising the opportunities of being more entrepreneurial and commercially focused.

5. What are your relationships like with your CCGs?

Good. Our CCGs have high expectations of us in terms of supporting them but we have a strong commitment from them; we have kept all our local CCGs and have added significant pieces of work from public sector clients that recognise our strengths in key areas. We continue to have fruitful discussions with a wide range of organisations.

6. What relationships do you have with other stakeholders?

We have a contract with Warwickshire County Council to offer support for public health and we are hosting an audit service. We also have agreements in place with other CSUs for data management, regional services and procurement support and are providing support to our local area team (LAT).

As mentioned, we have a successful partnership with a third sector organisation called The Young Foundation to deliver their social entrepreneur in residence programme.

7. What is your view on private sector involvement?

We haven't engaged with the private sector in the way some other CSUs have. Because we are a smaller CSU and we have had a strong in-house team from the beginning, we have done a lot of work ourselves. We have used a company called Provox Consultancy for additional financial support. Our strategy is to

Facts and figures

Locations: Warwick (HQ), Coventry and Worcester

CCGs

- > NHS Warwickshire North CCG
- > NHS South Warwickshire CCG
- > NHS Coventry and Rugby CCG
- > NHS Wyre Forest CCG
- > NHS Redditch and Bromsgrove CCG

Patient population: 1.4 million

Percentage of income from CCGs: 88%



expand our work with other NHS and public sector organisations. We may outsource our back office functions such as HR and IT in the future to organisations that can deliver these more cost effectively at scale.

8. What are the major challenges of working in a CSU?

Starting an organisation from scratch is tough and we are always trying to develop a more commercial focus. The majority of staff are from a PCT background, so keeping that customer focus and not being the lead commissioner is a journey our staff are having to take. In addition we are working in an extremely complex environment with multiple stakeholders, which can be challenging. These issues all form part of our on-going organisational development, and we have a programme to look at how we structure our performance management of staff to be more commercial.

9. Where do you see your CSU in 2016, post NHS England hosting?

We are working towards independence from NHS England by 2016. We are currently talking to our staff about what autonomy would look like and the options for the organisational form, whether it's a mutual or a social enterprise and whether the employees or others would be partners. We are expecting further guidance from NHS England later in the year.

Biography

How does your career so far help you in your role as a CSU managing director?

I came into NHS management through the NHS training scheme 21 years ago. I have held a variety of roles across the NHS and recently in commissioning. I came to NHS Warwickshire as Assistant Chief Executive becoming Director of Delivery Systems in April 2011 when Warwickshire and Coventry PCTs merged. I then moved into managing NHS Arden Commissioning Support and became Managing Director in June 2012.



Why did you take on this role?

I took on this role for the challenge of starting up a new organisation. I saw the huge opportunity to develop a different kind of NHS organisation, particularly around commissioning. Creating an organisation that has public sector values and a commercial focus is an exciting prospect.

Life outside the CSU: I am a vice chair of a non-statutory health and wellbeing organisation in Gloucester. I live in the Cotswolds and so enjoy being outside. I have two young sons who keep me busy.

NHS Central Eastern

Commissioning Support Unit

Managing director: David Stout

1. What services do you provide?

Central Eastern commissioning support unit (CSU) offers end-to-end commissioning support including:

- > Transformational and strategic change services such as business intelligence, procurement and market management and contract management
- > Business and corporate services such as finance, human resources and governance support
- > Clinical and operational services such as continuing healthcare and medicines management/optimisation
- > ICT business services

2. How are you structured?

We are a large CSU covering quite a wide geographical area, but we understand the importance of delivering a truly local service to our clinical commissioning groups (CCGs) so our structure reflects this. We have three business units: one covering Essex; another for Hertfordshire, Bedfordshire and Luton and a third providing ICT business services including IT support services for CCGs, GP

practices and NHS trusts. Some functions such as finance, procurement and HR are shared across the business units. Our CCG customers receive high quality services, often by staff embedded within the customer's organisation who are therefore fully in tune with their needs and requirements. Each CCG has a key account manager who ensures that the lines of communication between customer and CSU remain open at all times and any issues are resolved quickly.

3. What regional challenges does your CSU face?

In Essex, two out of our five hospitals – Colchester and Basildon & Thurrock – were reviewed as part of the Keogh mortality review into the quality and care of 14 hospitals across the country. Basildon & Thurrock University Hospitals Foundation Trust was placed on special measures following the review.

A recent CQC review of Colchester Hospital University NHS Foundation Trust recommended that this FT is also placed on special measures.

A number of local providers and commissioners face significant financial pressures. Furthermore, in Hertfordshire, none of the acute hospitals are foundation trusts (FTs), so there's the challenge of taking these through the FT pipeline.

4. What are your strengths and weaknesses?

Our key strength is our local knowledge of the patch and our ability to deliver end-to-end commissioning support. Our size means we are able to benefit from operating at scale with high quality, expert leadership. Our team at the top brings together a wealth of experience from the NHS and the private sector, so we are able to blend commercial and technical expertise with NHS knowledge and insight. For example, we have a number of clinically-based services such as medicines management optimisation and continuing health care led by a director of clinical services who provides professional direction.

We are investing in the development of our service to support CCGs. We are an

at-scale provider of procurement services and are putting in place a strategic partnership with an external organisation so that we get the benefits of that expertise. Effective procurement will be a key way CCGs can deliver significant changes in future. This will involve not just any qualified provider but also more ambitious ideas such as the prime contractor model where CCGs contract with one lead provider which is financially and clinically accountable for the whole patient pathway. This integrated approach puts the onus of service improvement and quality onto providers and potentially transfers risk from commissioners to providers. One of the CCGs in our patch, Bedfordshire, is leading the way with this innovative approach. We are also investing in improvement in our business intelligence services, as we see these as critical to providing support to our CCG customers.

We have brought together people from different organisations and areas where they have not done things in the same way. We are working on the question of to what extent we want to unify services across the patch or tailor them to the CCGs. The trade-offs are between economies of scale and providing bespoke services to meet individual customer needs. Like the rest of the NHS, we are also currently restricted in the range of services we can deliver using patient identifiable data.

5. What are your relationships like with your CCGs?

We have established good relationships with our customers, and we are just completing a round of formal reviews of performance in the first few months of operation. We are working hard to deliver to CCGs' standards and to build on our good start with a positive professional relationship.

Our key account manager structure allows us to keep in touch with what our customers need from us. Our vision is to be the CSU of choice for CCGs, and to do this we must demonstrate a good track record in delivering what we promise and exceeding customer expectations. Despite there being lots of familiar faces around, it's not a cosy relationship by any means and our CCGs are

Facts and figures

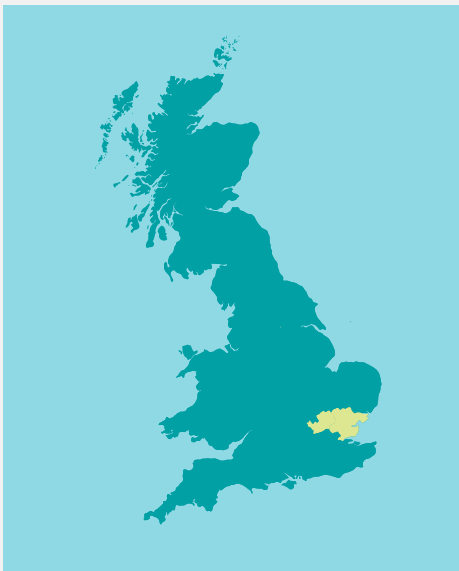
Location: Four main offices in Bedford, Welwyn Garden City, Basildon and Witham

CCGs

- > NHS Bedfordshire CCG
- > NHS Luton CCG
- > NHS East and North Hertfordshire CCG
- > NHS Herts Valleys CCG
- > NHS Thurrock CCG
- > NHS Basildon and Brentwood CCG
- > NHS Castle Point and Rochford CCG
- > NHS Mid Essex CCG
- > NHS West Essex CCG
- > NHS North East Essex CCG
- > NHS Southend CCG

Patient population: 3.5 million

Percentage of income from CCGs: 80%



rightly expecting ongoing improvements from our services, which we are striving to deliver.

6. What relationships do you have with other stakeholders?

We have excellent links with the local councils in our area and provide a number of services to them. Other customers include the local mental health and community providers, which we provide with IT services and some business intelligence services. We also provide a number of services to NHS England's area teams in our patch.

7. What is your view on private sector involvement?

We are very open to working with private and voluntary sector partners where we believe that will add value to our CCG customers. We work alongside MedeAnalytics, an independent sector provider of data analysis, which is an arrangement we have inherited from the primary care trusts (PCTs). They provide analysis of clinical activity, breaking down acute service use by general practice. This is important for CCGs to help them engage with practices. This covers nearly the whole CSU area apart from North East Essex and Mid Essex. We have a short-term contract with Attain, a private sector health commissioning company, to support our procurement service. We are looking to establish a longer term strategic partner for this service in the coming months. We are exploring establishing further partnerships with third sector and private providers where it can increase efficiency or add capacity.

8. What are the major challenges of working in a CSU?

The main thing is the culture change. Getting people to think in a new way; to become more customer-focused. Our staff are enthusiastic about working in new ways and are working hard to ensure we are a flexible, responsive and innovative organisation while still retaining NHS values.

9. Where do you see your CSU in 2016, post NHS England hosting?

We are keen to achieve autonomy so that we

Biography

How does your career so far help you in your role as a CSU managing director?

I was deputy chief executive of the NHS Confederation and a PCT chief executive, but the latter was some years ago. While the world has changed radically since I was a PCT chief executive, I have a good understanding of the business of commissioning and what the core tasks are.

My role at the Confederation helped me to understand the health policy landscape through following the ins and outs of the passage of the Health and Social Care Bill, and as PCT network director at the Confederation I saw what some really good PCTs were doing and I have good links at a national level. As the Confederation is a charity, I understand the need to operate as a business. There were no guarantees; I had to bring in investment, so there was a degree of commerciality which has given me a good insight into the commercial aspects of running a CSU.



Why did you take on this role?

Working at a national level I'd make endless speeches about the challenges facing the NHS and I felt it was the right time for me to do something about it in a more hands-on way.

I was looking for the opportunity to work at the coalface and be part of planning care for a population of 3.5 million. Running a CSU is definitely an interesting challenge to be more commercial, where you succeed or fail by how good you are.

Life outside the CSU: I live in North London and I am married to the newly appointed chief inspector of Adult Social Care at the Care Quality Commissioning, so we are both pretty busy. I am learning to play the saxophone and I am a Tottenham Hotspur season ticket holder.

become a standalone organisation in our own right. We are looking to establish partnerships to ensure that we successfully get onto the Lead Provider Framework for commissioning support services when that is introduced next year. We remain open-minded about the form the organisation will take once we become autonomous.

NHS Central Midlands

Commissioning Support Unit

Managing director: Rob Bacon

1. What services do you provide?

We provide twelve service lines. One of the most important is supporting the quality innovation productivity and prevention (QIPP) programme, where we excel, particularly with our strategic commissioning support team.

We are helping commissioners look at the configuration of services and how to improve quality and value for money. We look at whole system redesign, using business intelligence to present commissioners with options for change and care services redesign, business intelligence and systems usage. We have recently improved our offer by including data from local authority sources allowing us to present a whole system picture of health and social care.

Also, we support implementation with our skilled and experienced project management, finance and communications and engagement staff.

Another key area is quality assurance in light of Francis. We have a strong department led by a nurse director.

The areas that we support include board level reporting on provider performance and themed reviews on topics such as dignity and learning disabilities as highlighted by the care quality commission (CQC).

We look at workforce assurance, looking

at the way services are delivered including staffing levels and skill mix of wards.

We do the foot work and talk to staff, and look at the issues they are raising. We take urgent action where safety issues are raised and also provide follow through, dealing with matters brought to our attention by the CQC.

We look at the patient experience and triangulate that with information on quality. We offer the key elements of a quality service which will help clinical commissioning groups (CCGs) be effective commissioners.

2. How are you structured?

We have a leadership team of seven including my role. We have directors of finance, business intelligence and quality, and leads for governance, communications and business development.

We embed 70 staff with CCGs. If you visit the CCG you would see our staff fully integrated into the CCG, but we provide the added back-up of skills and numerical strength – such as cross cover if someone falls ill.

We have relationship managers who go into the CCGs to ensure they are happy with our delivery.

3. What regional challenges does your CSU face?

A key issue is the emergency care system. All parts of it are under huge pressure with rising accident & emergency attendance and medical emergency admissions, which have increased over the last year. The reasons for this are multifactorial. The underlying issue is the rise in number of frail elderly people with complex health issues including long-term conditions. Essentially that's the challenge CCGs need to work to address with support from the commissioning support unit (CSU).

4. What are your strengths and weaknesses?

One of our strengths is our business intelligence offer, in particular our management intelligence commissioning service (MICS), which provides CCGs and GPs with real time data of hospital activity and costs. Our CCGs are also a strength as they are

very switched on. They have really tested us, which has helped us improve.

The challenge is bringing together all CSU staff from different organisations across Birmingham, the Black Country and Solihull, integrating systems and developing our people to be more commercially aware.

5. What are your relationships like with your CCGs?

Very positive. Some are buying up to 90% of our services; some are doing more work themselves and buying 50% to 60% of our services. I want to move to a situation where they look at us as an extension of their organisation and as part and parcel of their management decisions. We are part of their team no matter how much they buy from us, so they have got that commitment from us.

6. What relationships do you have with other stakeholders?

We have a data management and business intelligence contract with NHS England's area team for specialist services in the West Midlands. We also provide an at scale data management service for parts of Wales, Surrey and Guernsey.

We partner with a number of CSUs to provide data management and communications and engagement, and we provide web service solutions to about 30 CCGs. We also work with two local authorities on their strategic review model.

7. What is your view on private sector involvement?

We are constantly looking at the prospect of partnering opportunities with the private sector and indeed other public sector organisations. There are areas where we can combine our expertise and local knowledge with more specialist skills in a particular product or service that a partner can bring. The CSU will always source a private sector solution where this is of benefit to the customer.

8. What are the major challenges of working in a CSU?

The challenge is to redesign the way we

Facts and figures

Location: West Bromwich and Kings Norton, South Birmingham

CCGs

- > NHS Birmingham Cross City CCG
- > NHS Birmingham South Central CCG
- > NHS Dudley CCG
- > NHS Sandwell and West Birmingham CCG
- > NHS Solihull CCG
- > NHS Walsall CCG
- > NHS Wolverhampton CCG

Patient population: 2.5 million

Percentage of income from CCGs: 82%



work and change the culture. We need to be innovative and quick to bring things to market in an environment where we are competing with the private sector, along with CCGs doing work in-house. We hope they come to us but we know it's not a given. We recognise their right to choose and I think that has motivated staff to cut through the red tape we have found in the past. This helps support better patient care, which is what everyone gets out of bed for.

9. Where do you see your CSU in 2016, post NHS England hosting?

We expect to be working in the independent sector. We will be looking at the model that best meets our requirements. My understanding is that NHS England will agree a range of governance models later in the year.

Biography

How does your career so far help you in your role as a CSU managing director?

I have 15 years' experience of leading complex organisations in the NHS and I was most recently cluster chief executive for the Black Country. I gained my commercial experience training as an accountant with the Chartered Institute of Management Accountants.



Why did you take on this role?

Because it is the most interesting leadership challenge in the NHS. You get an opportunity to think about how to respond to the demands of our customers. There are no national standards to meeting those challenges, it's determined commercially by us and our teams. We have to change the culture and the way people work in the NHS. We have to encourage team working, respond to the customer and create a dynamic organisation.

Life outside the CSU: I am refurbishing an 18th century farmhouse and I enjoy spending time with my family.

NHS Central Southern

Commissioning Support Unit

Managing director: John Wilderspin

1. What services do you provide?

We are a big commissioning support unit (CSU), and we provide a wide range of services but not necessary all things to all clinical commissioning groups (CCGs). By and large this relates to size. Smaller CCGs generally have bought more, bigger ones generally commission more in-house.

We have nine major service lines and offer more than 30 individual services. These align with NHS England's descriptor of six overall service themes likely to be offered by CSUs. Service lines run all the way through the commissioning cycle and include service redesign, strategic planning, procurement, contract negotiation, provider performance management, quality assurance and commissioning for quality. The way we do that isn't just by looking at money and activity and traditional measures; we are looking at

outcomes. We want to make sure we support CCGs to commission quality. We aim to support CCGs to deliver the recommendations in the Francis report by focusing on outcomes for groups of patients and individual patients, on patient safety and patient experience.

We also cover the transactional and back-office side of commissioning so finance, human resources, communications and IT. These areas underpin high quality information and support to improve the commissioning of good quality care.

2. How are you structured?

We benchmark ourselves against other providers and we have got to predict what future needs may be.

We've made good progress in evolving from a traditional primary care trust (PCT)-type organisation into much more of a 'matrix' structure. If you want to provide a good service and work towards the customer then you have to work like a business.

So for example, the finance manager looks at how they can go beyond providing finance services and work with CCGs. An account manager is responsible for customer care and every aspect of the service. They are the point of access for our customers. They work to make sure we've brought together all individual service lines into a package for the customer. They bring individuals from the different service lines in the CSU to the same team working for that customer.

We have separate people who lead on delivering excellence, these are the service line managers.

3. What regional challenges does your CSU face?

We cover an area half the size of Wales – Buckinghamshire across to Gloucester and down to Wiltshire. So it's a very big patch. We have some CCGs which are very rural and some much more urban. Some of our patch is well-off with good health outcomes, but in contrast there are big issues around Slough which is quite deprived and with poorer outcomes. Furthermore, there are also challenges around demographics with a significant older population. We have to

continue to improve quality where resources are limited.

4. What are your strengths and weaknesses?

The obvious thing is our size and the opportunity to share good practice across the whole of the geography. From Gloucester to Slough staff will pick best practice up quickly and feed it back to their colleagues and customers.

We are bringing all our customers together into a customer reference panel where they get a chance to share information as well as talk to us. With these economies of scale we will be able to do new things and build in flexibilities to deliver our skills and resources to maximum effect.

We need to work on our unique selling points with our customers. We are focusing particularly on five key areas: transforming services for patients; driving efficiency in healthcare providers; promoting quality in all healthcare services; helping our customers to run their business effectively and efficiently; and helping them to evidence everything they do.

It will be interesting to see how it evolves. As staff talk about building a CSU, they are excited. There will be stuff we can do we haven't dreamed of, that's where it can get fun.

Our weakness is also our size. We need to make sure we are sensitive to the different needs of our customers. We are striving to have personal relationships.

5. What are your relationships like with your CCGs?

We have good relationships with CCGs. It's a large patch and issues vary, but we are working closely with our customers. We have a customer reference panel where we can get feedback about what they want us to do.

6. What relationships do you have with other stakeholders?

We have won a bid to work with NHS England on military provision given that we cover a lot of that geography. We are adding new

Facts and figures

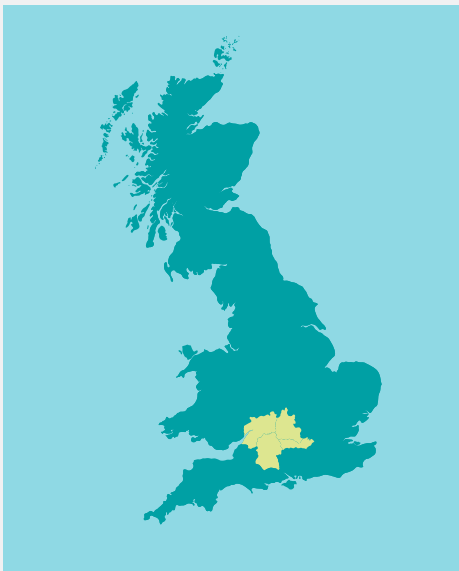
Locations: Newbury (HQ), Gloucester, Swindon, Devizes, Bath, Reading, Windsor, High Wycombe and Oxford

CCGs

- > NHS Aylesbury Vale CCG
- > NHS Chiltern CCG
- > NHS Oxfordshire CCG
- > NHS Gloucestershire CCG
- > NHS Bath and North East Somerset CCG (BANES)
- > NHS Swindon CCG
- > NHS Wiltshire CCG
- > Berkshire West Federation
- > NHS Newbury and District CCG
- > NHS South Reading CCG
- > NHS North & West Reading CCG
- > NHS Wokingham CCG
- > Berkshire East Federation
- > NHS Windsor, Ascot and Maidenhead CCG
- > NHS Slough CCG
- > NHS Bracknell and Ascot CCG

Patient population: 3.6 million

Percentage of income from CCGs: 75%



customers all the time - from specialist informatics work with a CCG in Surrey and with some of the new Academic Health Science Networks, to large-scale support for GP IT across our whole patch.

We are slightly unusual in that we grew substantially even before we formally came into being so we started as a Thames Valley, Gloucestershire and Swindon CSU, then were joined by Wiltshire and Bath and North East Somerset.

It's inevitable that CSUs are going to consolidate further. The first priority is that as a big organisation we are responsive to each customer after that we could look at who else might value our service.

We also want to develop partnerships with local authorities. If we are going to provide a really great service to CCGs we need to be working with the people they are working with. An example is public health if we are going to provide top class healthcare intelligence we need to work with Public Health England, CCGs, local authorities and NHS England to present a really rich picture. We have started talking to public health directors and PHE.

7. What is your view on private sector involvement?

I want to relate to other people providing commissioning support whether they are social enterprises or in the private sector. If there are people out there we can learn from, who provide a service that our customers need that we can't yet provide, we'll work with them.

As examples we are working with both Heart of Birmingham NHS Foundation Trust, but also with Sollis plc on different aspects of data management and information to support commissioners.

8. What are the major challenges of being a CSU?

The first thing we have to do is demonstrate "added value." Our first objective is to provide a high quality service to our current CCGs so we retain existing customers.

The current challenge is that we, like them, are going through a massive transition, some staff are permanently with us, some are

Biography

How does your career so far help you in your role as a CSU managing director?

I have come from a role at the Department of Health where I was leading the implementation of health and well being boards. Prior to that I worked in PCTs and in the Modernisation Agency and before that I spent 17 years involved in running hospitals.



Why did you take on this role?

It's an opportunity to build a new organisation from scratch. To do some of the things which I did in part in a PCT but never had the chance to take through to fruition such as developing top class health intelligence capability and commissioning for outcomes, patient experience and safety rather than principally for national targets. It also allows me to support clinical commissioning which is something I am very passionate about.

Life outside the CSU: I help coach my daughter's under 18 rugby team. I love travel, wine and cooking.

seconded. That makes it very hard to provide the desired level of quality right now. However, everybody is realistic that we are providing some of our services at a very early stage, even before we formally came into being.

9. Where do you see your CSU in 2016, post NHS England hosting?

We are very confident that we will be a successful NHS CSU which is ready to go into a fully competitive market as a stand alone organisation. At the moment our host organisation expect us to live within our means and grow our business. We have to think of ourselves as a business from day one. We will ask our staff and customers what they would like to see. Some people are very keen on working in a partnership model and or social enterprise model.

NHS Cheshire and Merseyside

Commissioning Support Unit

Managing director: Tim Andrews

1. What services do you provide?

We offer full commissioning support to our customers, combining a wealth of services and professional expertise to help them through the operational and delivery process from start to finish. Our services range from business planning and contract management, to communications, human resources, finance, procurement and medicines management.

We offer six core service portfolios designed to reflect all key elements of the commissioning lifecycle, providing an integrated, flexible and expert service:

- > Strategic and Business Planning
- > Performance and Contract Management
- > Service Redesign and Transformation
- > Clinical Services
- > Technology
- > Corporate Support

2. How are you structured?

Our structure is designed to meet the needs of clients as well as delivering excellence in operational delivery.

Our delivery approach is built upon building local relationships through client-facing teams, complemented with access

to experts on demand and central business teams. Our local presence is led by a senior client operations leader who has an in-depth understanding of commissioning support services (CSSs) and the client's environment. These leaders are building good relationships and confidence in our commitment to excellent service. Our multi-disciplinary locality teams are embedded within client teams, supporting every component of our services.

Some of the skills and talent required for delivering our services is specialist and only required for parts of the commissioning or business cycle. Our delivery model offers access to specialists to support tailored services such as service redesign and transformation.

3. What regional challenges does your CSU face?

We are a microcosm of the whole country. There is rural leafy Cheshire and inner city Liverpool – it's a very diverse and challenging mix. There are some very significant elderly populations in areas such as Southport and Formby and on the fringes of Cheshire where there is a big retirement community. Other areas have high levels of deprivation and poor health. Our people have experience of this diversity and an in-depth understanding of the populations and health systems we operate in.

4. What are your strengths and weaknesses?

Our strengths are derived from where we can add real value to our clients.

- > We deliver specialist skills and capabilities which are difficult to replicate within clinical commissioning groups (CCGs); such as business intelligence (BI); quality and performance; engagement, patient experience and the whole transformational agenda.
- > We provide resilience against fluctuating demands and responsiveness to new commissioning challenges, including delivery around annual planning/contracting, urgent remediation issues and large scale transformation.
- > Due to our broad geographical spread we are able to support collaboration by

providing shared services and strategic support that practically connects commissioning organisations and facilitates integrated solutions across health and social care.

- > We are an ideas aggregator; our specialist skill-base means we can identify, collate and interpret best practice and insight in very practical ways across commissioning boundaries and we can adapt to provide local solutions.

Like all commissioning support units (CSUs), our first year has been about organisational development alongside achieving service stability and planning for growth. Establishing any new organisation is a huge challenge; we have made great strides but our plans are ambitious and there is still much we wish to do to improve our services and their scope.

5. What are your relationships like with your CCGs?

Every CCG client is different in the services they buy from us, and although relationships are positive, they all quite rightly have high expectations and standards.

The key to success is to have strong client relationship management, with two-way communications and robust governance. At times our clients are tough on us as they want our support to match their ambitions. There is a strong joint commitment to make this work, but we are clear that our clients have a choice; we need to deliver and show how we add value.

6. What relationships do you have with other stakeholders?

We work closely with the NHS England area teams in Cheshire and Merseyside, both as clients and as stakeholders.

We are also forging positive relationships with local authorities. We see huge benefits for clients in CSUs supporting collaboration and integration across health and social care, whether this is through joined-up business intelligence or transformational support.

Provider relations are now also starting to develop. We are already providing ICT to a number of them, and there is a lot of interest

Facts and figures

Locations: Chester, Liverpool, Birkenhead, Warrington and Nantwich

CCGs

- > NHS Southport and Formby CCG
- > NHS South Sefton CCG
- > NHS St Helens CCG
- > NHS Knowsley CCG
- > NHS Liverpool CCG
- > NHS Halton CCG
- > NHS Warrington CCG
- > NHS Wirral CCG
- > NHS West Cheshire CCG
- > NHS Eastern Cheshire CCG
- > NHS South Cheshire CCG
- > NHS Vale Royal CCG

Patient population: 2.3 million

Percentage of income from CCGs: 70%



in our BI solutions that will enable much closer data integration between providers and commissioners.

7. What is your view on private sector involvement?

We aren't focused on the public v private sector debate. We are strongly committed to our public service ethos but we also know that in some cases we can offer a better service by partnering with private sector organisations that offer skills and experience which enhance the value of our services to clients.

We are developing partnerships and relationships with a raft of external organisations, agencies and consultancies, so we can bring in skills and capabilities to augment our capabilities. One of our strategies is the flexible resource pool which, through agreed procurement routes, will enable us to identify and access resources that can support delivery of bespoke projects or support resilience in delivery if demand increases. The pool will include our partnership resources, from third sector organisations to potentially global professional services organisations.

8. What are the major challenges of working in a CSU?

CSUs are professional service organisations. I spent 10 to 15 years in outsourcing and 10 years in law as a solicitor in a corporate law firm so I think a CSU is a sort of hybrid of both. It's not like a big accountancy practice or a business management consultancy, nor is it really a pure outsourcer such as Capita or Serco.

We have to recognise that everything we do has a customer and they want value for money. In the private sector that is a consideration, as if you don't deliver a good service you don't get business. But it should also be seen as an important element of public sector work. CCGs have that critical choice but it's not such a big shift in culture and if it is it shouldn't be.

9. Where do you see your CSU in 2016, post NHS England hosting?

We are starting to think through our options

Biography

How does your career so far help you in your role as a CSU managing director?

I am used to working in two extremely commercially competitive environments with long days. Corporate law has a certain cultural reputation as does outsourcing to a degree.

But my experience was of working in inspiring cultures with dynamic and enthusiastic staff. If we can get staff motivated and enthused we will be pointing in the right direction.



Why did you take on this role?

One of the things I say to staff who see my CV is that my mum was a nurse, my dad a policeman, my sister is a nurse who now works for a CCG in Hull and my brother is a charity worker. I spent five years in a high street law firm before going to university, so I came from a very strong public sector orientated environment. It's stuck with me. The CSU offers me a chance to bring all of my experience in the private sector back into the fascinating but hugely challenging public sector. I am really excited about that opportunity and feel very privileged to have the chance to help shape what I really believe are organisations with a huge role to play.

Life outside the CSU: I enjoy tennis, cycling and canoeing and I coach my son's under eights tennis team.

around externalisation. We have progressed well through the NHS England assurance processes and considered to be a viable and sustainable business proposition going forward.

We are going to take a completely open and transparent approach to exploring our options for the type of organisation we may become in the future. The first stage in this journey is to discuss this with all our stakeholders; most importantly our staff. Having established stability for our people after a long, difficult transition period, the last thing we want is to create a new sense of uncertainty. Our priority continues to be developing and improving our services and meeting the needs of clients. This is the right time to begin discussions about the future but it will not take centre stage or become a distraction to our core business.

Greater East Midlands

Commissioning Support Unit

Managing director: Professor John Parkes

1. What services do you provide?

We provide comprehensive commissioning support and business support services:

- > Commissioning Support Services
- > Clinical services (CHC and IFR)
- > Commissioning intelligence
- > Contract and provider management
- > Prescribing and medicines optimisation services
- > Procurement and market management
- > Service redesign
- > Business support services
- > Finance
- > Human resources and corporate services

- > IT services
- > Marketing, communications and engagement

2. How are you structured?

We have brought together the best skills and experience from former NHS organisations across the East Midlands. We have recently made some small changes to our structure in response to feedback from our customers.

We have three customer account directors (CADs) covering the northern, central and southern areas of Greater East Midlands (GEM), and a chief operating officer who focuses on ensuring operational delivery. We have also appointed a chief information officer.

Our CADs manage a team of customer account managers (CAMs) who ensure that we deliver to our customer requirements.

3. What regional challenges does your CSU face?

Inevitably we are a snapshot of other parts of the country. We cover a wide geography and some of the areas we cover have bigger challenges than others in terms of service quality, finance and performance. The underlying population demographic poses challenges - some areas are looking at service reconfiguration, some have got private finance initiatives, others haven't.

4. What are your strengths and weaknesses?

A key strength is our flexibility. Whatever a customer's requirement, we can deliver added value, high quality products and services at competitive cost.

We have strong skills and capability in data warehousing and we have developed strategic partnerships with solutions for public health, the strategic projects team and right care.

We work closely with our customers to understand their needs and deliver the right response – whether GEM staff are embedded into a clinical commissioning group (CCG), delivering an 'at scale' service on their behalf, or working with them to source additional partners. Our ambition is to go the extra mile

by either leveraging our scale or by bringing new thinking.

Some might say our scale is a risk but I don't accept that - I see it as much more of an opportunity.

5. What are your relationships like with your CCGs?

We have honest and frank relationships with our CCGs, each of us acting as 'critical-friends' in order to achieve success and results.

We continuously listen to our CCGs feedback, developing our understanding of their needs and responding quickly. We recently commissioned an independent third party to survey our customers, and tell us what was working well and where we needed to make improvements. This feedback was incredibly valuable.

Most CCGs want to establish a long term relationship it's not a lax, laissez-faire relationship; it's one that's professional. Where they benefit from working in partnership with GEM, and where we provide services which take advantage of our size.

6. What relationships do you have with other stakeholders?

We are working very closely with area teams, NHS England and local authorities. We have also developed strategic partnerships with solutions for public health, the strategic projects team and right care.

7. What is your view on private sector involvement?

We have developed a number of partnerships with the private sector and we have long standing relationships with McKinsey, KPMG and PWC.

8. What are the major challenges of working in a CSU?

We are commercially minded - how we continue to develop in this way, whilst meeting our customers' needs and keeping to NHS values, will be an interesting challenge.

9. Where do you see your CSU in 2016, post NHS England hosting?

The future is definitely bright. We are currently

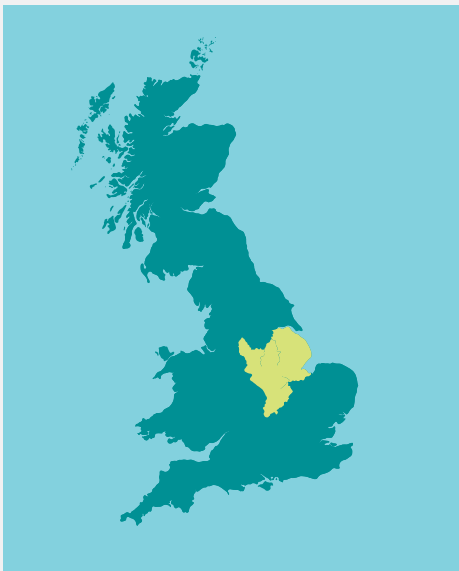
Facts and figures

Location: Moulton Park, Northampton.
Other GEM offices include: Birch House, Mansfield, Nottinghamshire; Cardinal Square, Derby; Cross O'Cliff, Lincoln; Scarsdale, Chesterfield, Derbyshire; Sherwood Place, Milton Keynes; St John's House, Leicester

CCGs

NHS Southern Derbyshire
NHS Hardwick
NHS North Derbyshire
NHS Erewash
NHS Leicester City
NHS West Leicestershire
NHS East Leicestershire and Rutland
NHS Lincolnshire West
NHS Lincolnshire East
NHS South Lincolnshire
NHS Lincolnshire South West
NHS Nene
NHS Corby
NHS Milton Keynes
NHS Rushcliffe
NHS Nottingham City
NHS Nottingham West
NHS Newark and Sherwood
NHS Mansfield and Ashfield
NHS Nottingham North and East

Patient population: 5 million
Percentage of income from CCGs: 80%



looking at a range of options and we look forward to working through these with NHS England over the coming months.

Biography

How does your career so far help you in your role as a CSU Managing director?

I was a PCT chief executive of NHS Northants and Milton Keynes and we were in the top 10 in the days of World Class Commissioning. I was then a cluster chief executive. I am also a professor of healthcare management at Northampton University where I mainly lecture on population health. I also sit on the independent reconfiguration panel looking at a major service review.



Why did you take on this role?

I could see the opportunity that CSUs can bring to healthcare and to enable CCGs to be successful to make the UK's health outcomes match up against other Organisation of Economic Co-operation countries through a shared agenda.

Life outside the CSU

I like going to the gym religiously, three times a week. I gave up alcohol on New Years Eve and I am seeing the health benefits already.

NHS Greater Manchester

Commissioning Support Unit

Managing director: Dr Leigh Griffin

1. What services do you provide?

We provide 14 services, with clients buying either some or all of them. We pride ourselves on providing clients with access to an unparalleled portfolio of tailored services, which encompass specialist clinical support, healthcare commissioning and business support services.

These include: effective use of resources, which helps clinical commissioning groups (CCGs) around individual funding requests; market management, which covers procurement on the CCGs' behalf; provider management, which covers contract and performance management; medicines management; service redesign; and communications and engagement. Business intelligence is also provided within our IM&T service, so it's a rich mix.

2. How are you structured?

I am the managing director, and there are four directors supporting me – a director of finance, a director of operations, a commercial director, and a partnerships director.

We have heads of service, reporting either directly to me or to a director, who are

responsible for the specific, individual services. We also have account managers who work with the CCGs, managing the totality of the delivery of service.

It is important to me that I do not describe the organisation in terms of the structure, because we use matrix management to deploy skills and capabilities fluidly. This also gives people the chance to develop skills and gain opportunities.

3. What regional challenges does your CSU face?

We are creating something different, on a larger scale, with an absolute commitment to customer care and relationship management at its heart.

For some people this has been quite a cultural shift. We put a lot of investment in our colleagues to enable them to thrive in a very different way of working.

Some of our clients may want things delivered in a way they are used to, and that may be right in some instances. Others will want different things so we have to tailor to individual clients' needs.

Of course there is the risk that they may want to look elsewhere. Some may be keener to do that than others so I want to give those clients confidence and assurance in us. We need to understand and focus on what our real strengths are, and in some services, look at partnering with other organisations or CSUs.

There is a range of challenges we face but the same fundamental challenge resonates across the NHS as we head through further years of QIPP and constraint, and really respond positively to the challenges of Francis.

4. What are your strengths and weaknesses?

A strength is our relationships. Greater Manchester is a geographical entity. It is a health system so we have the opportunity of working with that system. I think that it helps that there has been a history of collaboration across that system which we can build on. We have clients who want us to succeed, and we have put a lot of effort into understanding

and engaging with them. I think that is something clients value, and is certainly a strength. I also like to think that we have strength in terms of the quality of people we have employed. We have done a number of colleague surveys, and 70% of people say they feel they have the opportunity to influence the culture and they understand what we are doing. We need to build on that but it is not a bad starting place. I think our understanding of the Greater Manchester health system, our history of working with that system on an individual basis and our commitment to managing relationships are our key strengths.

A potential weakness could be our commercial awareness although we are learning fast. I think we have to balance a couple of things. One is to work with the health system and collaborate with them, and at the same time we need to be very clear about the cost and value of what we are doing. We need to understand that we are heading into a commercial market where we stand or fall by our comparative position and perception. There are some commercial skills which we clearly have on board. However, there is a need to build that awareness without losing the NHS commitment.

5. What are your relationships like with your CCGs?

I think they are good. As with all relationships, they can get better but we have put a lot of effort in. It has been important for us to understand that CCGs are not all alike. They have particular needs, cultures and styles. Some have more evidenced clinical leadership than others. Some have inherited real profound difficulties so it is important for us to get close. I meet with the CCG leads every week and write to them every couple of weeks. They each have a link director and we have a local presence in every CCG. I think there is a desire to mutually support and understand, but they are going to hold us to account. They have not got a great deal of resource, and they have a lot expected of them. We have to deliver for them. I do not kid myself, we will be held to account, and rightly so.

Facts and figures

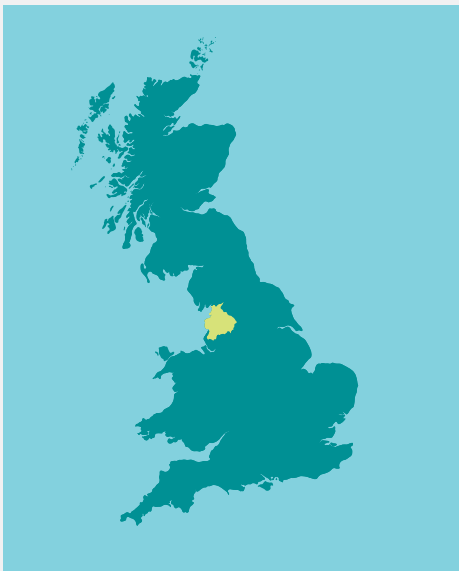
Location: Salford, Manchester

CCGs

- > Bolton CCG
- > Bury CCG
- > Central Manchester CCG
- > Heywood Middleton & Rochdale CCG
- > North Manchester CCG
- > Oldham CCG
- > Salford CCG
- > South Manchester CCG
- > Stockport CCG
- > Tameside and Glossop CCG
- > Trafford CCG
- > Wigan Borough CCG

Patient population: 2.8 million

Percentage of income from CCGs: 70%



6. What relationships do you have with other stakeholders?

I think they are steadily growing. We are an organisation that has grown significantly since October 2012 when we had 30 colleagues. We have now got 500. We have strengthening relationships with local authorities. We have a very good relationship with the NHS England area team. It is not a formal relationship in any regard, but it is a good dialogue and there is a mutual respect for our positions.

We have an emergent relationship with the trust network. We are keen to develop relationships with other partners, ranging from the voluntary sector to other parts of the statutory sector and the independent sector. Each of those sectors may provide partnership as well as client opportunities.

7. What is your view on private sector involvement?

The funding that the NHS receives needs to be used to best effect to improve health and healthcare, and to reduce inequalities. That is the bottom line. The NHS has always been a mixed economy. There are key parts of the NHS, for example, large chunks of primary care that have been at least quasi independent, but they have worked to NHS principles and have received funding through the NHS. That has worked; we have accommodated that. As we seek the best value for money we will continue to look at opportunities while remaining true to the basic values and principles of the NHS. I would not wish to see money taken out of the NHS. It needs to be used for its core purposes.

8. What are the major challenges of working in a CSU?

First of all, I can think of no job I would rather do. That is easy and glib to say but it is very heartfelt. The pace at which we are changing is daunting and challenging though - we are creating something fundamentally different. Many of us are unaware exactly what shape the market will take and what balance there will be that will settle between the collaborative and the competitive side of the agenda. At times we will be competing for

Biography

How does your career so far help you in your role as a CSU managing director?

I was a primary care trust chief executive for 10 years in a number of different locations, both in the North West - Sefton - and most recently in the West Midlands, in Telford and Wrekin and in Shropshire.

This is not a PCT or a chief executive role so I have to check myself on occasion. I am providing a service that is much more explicitly about provision to a range of clients, which stands or falls on the quality of delivery.



Why did you take on this role?

There is no job I'd rather do. I have led organisations through some quite challenging periods of change. The nature of NHS reform is such that I have had experience of setting up new organisations and closing them. I have also led organisations to tackle turnaround, fundamental financial and quality challenges.

Life outside the CSU: I live in glorious countryside with my wife, Judith, and a Welsh springer spaniel, Dylan. I am an avid supporter of Leeds United. While I do not get much time for chilling out at the moment, when I do, I like films, reading and walking.

work, but our absolute commitment to work with clients is at the heart of co-designing and delivering improvement.

9. Where do you see your CSU in 2016, post NHS England hosting?

I am optimistic that we will see success on a number of fronts. Not everything will run smoothly, I'm not foolish enough to think that. However I think in 2016 we will have delivered for our core clients and retained their loyalty. We may be providing more services for them and we may be providing services for others. I would hope that we would be providing services on a broader footprint.

NHS Kent and Medway

Commissioning Support Unit

Managing director: Daryl Robertson

1. What services do you provide?

Kent and Medway commissioning support unit (KMCS) provides a combination of operational and transformational commissioning support to clinical commissioning groups (CCGs) and other customers. Our services include:

- > Integrated provider management
- > Operational commissioning support
- > Strategic change services
- > Corporate services
- > HR and organisational development
- > Consultancy services

2. How are you structured?

KMCS operates through six business units although our services are delivered in a matrix style to ensure that delivery to our customers is integrated, outcome-based and efficient. Many of our staff joined the commissioning support unit (CSU) from local primary care trusts (PCTs) but a number have come from other NHS organisations and from outside the NHS so each team can draw on a wide range of NHS and commercial experience.

The way we work has changed significantly since the formation of the CSU: we use our collective experience of commissioning NHS services, and enhance it with increasingly robust monitoring and a focus on outcomes, drawing on the commercial expertise we have brought in.

Our business units are led by a highly experienced executive team comprising of staff with significant and varied NHS experience as well as individuals with commercial experience at a senior executive level.

3. What regional challenges does your CSU face?

Like other CSUs, KMCS is working with our customers to rapidly embed commercial expertise in a patient environment and supporting CCGs to develop into mature organisations that commission safe and effective services. We cover an area where different parts of the population have very different health needs, so we have to be able to tailor the support we provide to enable each CCG to work effectively for their local population. On top of this, we need work in partnership with CCGs to use innovation to underpin future efficiency savings

The providers that our CCGs commission are facing significant challenges, with a large private financial initiative (PFI) scheme in one Trust, a potential FT merger being considered, and safety concerns highlighted through the Keogh review. Our challenge is to support local commissioners to lead a safe, affordable and sustainable health system, and to balance the conflicting priorities that this presents.

In autumn 2013 KMCS will start to provide services to CCGs in Surrey and Sussex, so we face the challenge of building relationships with commissioners and providers to help secure a stable and sustainable commissioning landscape. CCGs in the area have already been through an extended period of uncertainty regarding commissioning support provision, and we need to rapidly embed new ways of working that give our new customers confidence in our services.

4. What are your strengths and weaknesses?

Strengths

- > Our experienced team including recognised national experts in specialist areas
- > We have used our combined experience to develop new ways of working: for example, our integrated provider management service now combines previously fragmented contracting, procurement and performance intelligence services
- > We are using innovation to deliver services
- > Our partnership approach that brings together academic, industry and public sector knowledge to focus increasingly on collaboration and outcomes
- > We are focused on quality customer delivery – KMCS wants to be the best and not necessarily the biggest CSU

Challenges

- > Like all CSUs, KMCS is having to adapt to a new commercial environment and retain and attract specialist skills. As ever before, we are focused on supporting the delivery of high quality patient care. However, working in a similar context but with new customer relationships is a challenge to all staff. We are addressing this through customer-focused training, and regularly seeking feedback from our customers.

5. What are your relationships like with your CCGs?

CCGs and CSUs have both been on a long and often testing journey to establish new organisations and go through demanding authorisation processes. This has been challenging, often requiring patience and understanding on both sides. We are confident that we can now continue to build on previous successful whole system working to deliver a seamless service for patients in partnership with GP commissioners.

Our relationship with each CCG is different: each one is building its own culture and approach, and our role as a CSU is to understand that and adapt to it. Quite rightly, CCGs are asking a lot from their CSU, and we need to work hard to demonstrate tangible outcomes to show that we can

Facts and figures

Location: Ashford (HQ), Harrietsham, and Maidstone and Lewes

CCGs

- > NHS Medway CCG
- > NHS Dartford Gravesham and Swanley CCG
- > NHS West Kent CCG
- > NHS Thanet CCG
- > NHS Swale CCG
- > NHS South Kent Coast CCG
- > NHS Ashford CCG
- > NHS Canterbury and Coastal CCG
- > NHS High Weald Lewes Havens CCG
- > NHS Hastings and Rother CCG
- > NHS Eastbourne, Hailsham and Seaford CCG
- > NHS Horsham and Mid Sussex CCG
- > NHS Crawley CCG

Patient population: 2.7 million

Percentage of income from CCGs: 88%



meet the standards they expect from us. To better understand our relationships, we have developed a quarterly Value Curve review to capture feedback from each CCG, and our customer Account Managers will use this to prompt regular discussion about what we're doing well.

As a result of the strong relationships we have developed, we are working closely with a number of CCGs on joint projects to explore new opportunities in patient care. We have very recently jointly presented our work with CCGs on advanced assistive technology at the Healthcare Innovation Expo and on our Innovation Model at the Commissioning Show. We are also working with CCGs on the key priorities such as dementia, and developing a collaborative Innovation Forum.

6. What relationships do you have with other stakeholders?

As well as working with CCGs, KMCS provides services to the Department of Health, Kent and Medway Area team, and other local organisations. We also recognise the need for increasingly integrated working, and we liaise regularly with not-for-profit organisations, providers and local authorities. We have a number of acknowledged specialists working on national level projects or on expert groups.

We also have strong relationships with a number of leading organisations in the technology industry participating in the KMCS-led Industry alliance.

As well as building customer relationships with non-CCG customers, our aim is to use our relationships to facilitate collaborative working and learning opportunities that offer mutual benefits to our customers and other stakeholders.

7. What is your view on private sector involvement?

KMCS is committed to working in partnership with industry and academia to ensure we are delivering high quality services – our customers expect us to have access to the latest and best knowledge, skills and practice.

Some of our services are delivered in partnership with other NHS support services organisations as we realise some services are

Biography

How does your career so far help you in your role as a CSU managing director?

I have a broad and varied NHS career portfolio coupled with broader life experience. This helped me ensure we retain a public sector ethos while developing an organisation that understands and responds to having to excel and compete in a commercial context.



Why did you take on this role?

It was an outstanding opportunity to help break the mould and make a real difference in how patient care is commissioned and delivered by providing effective, efficient and innovative support services.

best offered at scale or require specialist skills and knowledge.

KMCS is also using partnerships in innovation to underpin its service offering, and is currently developing an Innovation Forum:

- > In partnership with CCGs, we are discussing and developing new ideas giving a voice to the creative thinkers and making time and space for innovation. Our academic, third sector and industry partners will be increasingly involved in these conversations as the Forum develops over the coming months.

Like other CSUs, KMCS also worked with private sector organisations to develop some of our new ways of working during the authorisation process, and have engaged external input to provide capacity for additional work requests with CCGs - giving us a more flexible workforce. We see it as part of our role to secure arrangements for CCGs to access high quality external support.

8. What are the major challenges of working in a CSU?

We have supported staff through a period of unprecedented change while maintaining a safe and stable health system, and this challenge isn't over yet. We are still adapting to working in a changing commercial environment: some of our teams are starting to see the impact of the customer/provider relationships and are having to manage changing relationships with former colleagues.

Though this can be challenging, one of the roles of the CSU leadership team is to support our staff to find a successful resolution to issues and to ensure that customers are satisfied with the approach the CSU takes.

We are also entering another phase of transition as we start to provide commissioning support for CCGs in Sussex. Individuals who might be transferring into the CSU have already been through one transition process, and we need to support both new and existing KMCS staff through this process.

9. Where do you see your CSU in 2016, post NHS England hosting?

By 2016 our service offer will have evolved to meet changing customer needs, but KMCS will still be delivering high quality, innovative services to health and related non-NHS health and social care settings. We will be working proactively to identify a suitable operating model so that we can facilitate a streamlined transition for our staff and services. This will also need to reflect potential changes to the political landscape as well as building on the in-depth feedback we receive from our customers during our initial operating period.

NHS North and East London

Commissioning Support Unit

Managing director: Andrew Ridley

1. What services do you provide?

We provide the full range of commissioning support services (CSSs) including business intelligence (BI) and finance, contracting and quality, and procurement and market management. We also provide business support services such as communications, HR and IT as well as provide support to transformational change programmes. In addition to commissioning support, we also support provider organisations such as supplying IT services to GP practices.

Facts and figures

Location: Hackney, Camden and Redbridge

CCGs

- > NHS Barking and Dagenham CCG
- > NHS Barnet CCG
- > NHS Camden CCG
- > NHS City and Hackney CCG
- > NHS Enfield CCG
- > NHS Haringey CCG
- > NHS Havering CCG
- > NHS Islington CCG
- > NHS Newham CCG
- > NHS Redbridge CCG
- > NHS Tower Hamlets CCG
- > NHS Waltham Forest CCG

Other customers

- > NHS England, London and East Anglia regions
- > Central Eastern CSU
- > NHS Property Services Ltd
- > 11 Local authorities
- > A number of provider trusts, AQPs and prisons
- > GP practices in North and East London

Patient population: 3.5 million in North and East London, plus coverage across London and East of England for a number of services

Percentage of income from CCGs: Undisclosed

2. How are you structured?

We work in a matrix structure which is the only way to do it when you have service lines across multiple geographies. We have a leadership team of seven directors including myself. We have a chief operating officer (COO) and director of customer services, and directors of contracting and quality, finance, analytics, transformational change and corporate services.

We have nine account directors based out with our clinical commissioning group (CCG) customers and they are the voice of the customers in the organisation. They are very senior managers and they report to the COO.

The tone from the top is very much one of customer service. It is vital that we model this behaviour at all levels, so we have prioritised investment in organisational development with a particular focus on customer service, working with companies such as the Berkeley Partnership and the Performance Coach.

Our induction programme is called Welcome to the commissioning support unit (CSU). It's off site in a nice environment and people get to spend time with a member of the leadership team as part of the programme. It's also a good opportunity for people who are based in different offices, whether with customers, middle office or back office, to get to know each other.

We have embarked on an organisational development programme to make our organisation as efficient as possible to release efficiencies to our customers.

3. What regional challenges does your CSU face?

We operate in a particularly challenged and complex health economy. There are some major hospital reconfigurations underway in our patch. There is the reconfiguration of trusts in Barking and Dagenham, Havering and Redbridge and the BEH Clinical Strategy covers Barnet, Enfield and Haringey restructuring which includes the much discussed Barnet and Chase Farm hospital. We also have Barts Health, the largest hospital trust in Europe on our patch. We have a number of CCGs with

significant financial challenges – we have the most 'in deficit' CCGs in England, which is pretty unremitting, especially when you add the reconfigurations, the diverse population and rising demand.

4. What are your strengths and weaknesses?

We are a large CSU and have already grown considerably since we started so we can offer our customers some very clear benefits of doing things at scale. BI is a growth area for us. We provide BI services to NHS England across London and the East of England, and have just been awarded the contract to provide data management services to Central Eastern CSU.

Our strategy is to get to a big enough size so we can deliver further scale economies and also get to a point where people ask us to take things on because of our reputation.

IT, analytics, contracting, and managing complex change programmes such as reconfigurations are particular strengths of ours.

In terms of weakness, the funding formula is tough on our CCGs as the management cost is £25 per patient and this covers offices and staff but there is no London weighting. We have to do everything we can to make our offering affordable.

The change in culture is also a challenge. It comes back to our focus on customer service and reminding ourselves that we are acting in an advisory role to our customers.

5. What are your relationships like with your CCGs?

CCGs have got a tough job especially when you consider the challenge of the population of these London boroughs. We have very positive and collaborative relationships with our CCGs and are working hard to provide them with the support they need.

6. What relationships do you have with other stakeholders?

We provide business intelligence on specialist commissioning for NHS England in London and East Anglia, as well as a number of other services such as infection control for primary



care. We provide IT to small providers under any qualified provider (AQP) who need to connect to the NHS system and eight of our 12 CCGs have bought our offer to supply GP IT services. We are driving innovation in that area and we are working with Barts Health on integrated IT to support integrated care which may be something we could offer other providers.

We are also providing commissioning support to most of the local authorities in our patch to help them with commissioning sexual health services.

We have positive relationships with all our customers and think of them as our partners.

7. What is your view on private sector involvement?

Strategically I think many companies are keen to work with CSUs. There are some CCGs who will be comfortable working with 12 different suppliers, but others won't and they will work with the lead provider model where we are the principle contact with plural suppliers. So it will be like contracting with a department store for commissioning support.

If a CCG has a problem in a particular area, we will have multiple partners and associates in our supply chain who will be best placed to tackle it. We do that with IT engineers and I think we'll see more of that.

We are consulting on who to build relationships with. We have worked with the big consulting firms on many areas. McKinsey has done work on integrated care, Ernst and Young have worked on Barking, Havering and Redbridge integrated care and out-of-hours care and PWC have done work in Newham and Waltham Forest on financial recovery. PA Consulting Group has done project management for and with us. It really varies.

8. What are the major challenges of working in a CSU?

We can grow and, in that respect, we are not like a primary care trust (PCT). We have autonomy and choice, and it's quite exciting and buzzy when we win new business. We are more in charge of our own destiny with freedom to operate but the downside is that our income isn't guaranteed which is very

Biography

How does your career so far help you in your role as a CSU managing director?

I was at Tower Hamlets PCT for six years, starting as director of Primary Care and ending as acting chief executive. I then moved to East London and City cluster, which included Tower Hamlets, Newham and Hackney, and I was MD of the CSU for the three boroughs. We then merged with Outer North East London (ONEL) cluster and the central cluster. So I was pushed forward as an example when the policy was announced as someone who was already using the CSU model. We were a CSU in January 2011 before the national policy was launched. At that point, we had no service lines, no key performance indicators – we had to build it from the bottom up.



Why did you take on this role?

For the challenge and opportunity it presents. When in a PCT you always felt that no matter how good you were, you could only work in your area, but now we operate at scale and can spread good ideas further.

Life outside the CSU: I enjoy travel and wherever I have time, I try to see as much of the world as possible.

different for NHS staff. We also know there will be less money available in the system year on year for managerial services, so we are very focused on ensuring we are lean and efficient, and are providing value for money to our customers.

9. Where do you see your CSU in 2016, post NHS England hosting?

It is not a notable deadline. We are focusing on delivering business as usual and continuing to grow. We will focus on core areas and make strong links with other suppliers. Over time, we expect we will have a greater diversification of services and customers, but also a strong reputation for excellence in particular areas such as Business Intelligence.

NHS North of England

Commissioning Support Unit

Managing director: Stephen Childs

1. What services do you provide?

We offer a full range of commissioning support services, both transactional and transformation, everything from HR and finance to major service reform. An area of particular strength is our business intelligence; we have an in house tool RAIDR which is used now across 560 practices in the north.

2. How are you structured?

Our leadership team includes five directors and a senior medical advisor heading up key areas of finance, business development, commissioning support operations, business information services, organisational development and corporate services.

A key feature of our operating model is being disciplined about applying standard business procedures especially in project and programme management. We are developing a Project Management Centre of Excellence in our Enterprise Programme Management Office (EPMO) to make sure that the right people with the right skills and tools are deployed for each

project. Another key feature is our relationship management. We have five Heads of Customer Programme that cover specific areas and provide a single point of contact and support for customers.

3. What regional challenges does your CSU face?

We cover a very large and diverse population and have worked in collaboration with the Northern CCG Forum to understand and compare the population needs and commissioning priorities. We know, for example, there is a very high demand on urgent and emergency care and over-dependency on hospital beds is a common issue. The urgent care boards across the area are ensuring that they connect up to share learning and, in the same spirit, all CCGs have agreed to share examples of commissioning and primary care development best practice and innovation, with ourselves as the facilitator and broker.

4. What are your strengths and weaknesses?

We are in a strong position because of our scale, systems and standardised ways of working. At the same time, our staff have expertise and local knowledge and insight. We also benefit from:

- > Our business intelligence tool RAIDR which was developed with GPs
- > Our primary care demand management system (based on lean methodology)
- > Our care pathway transformation approach based on the Virginia Mason Medical Centre Production System
- > Our operating model, which includes time recording system, competency framework, and EPMO, designed in partnership with the Hackett Group

One of the major challenges we face, like other CSUs, is the cultural change - bringing staff from difference organisations together, and becoming totally customer focused and entrepreneurial in the way we grow our business.

5. What are your relationships like with your CCGs?

Our relationships with CCGs are very positive

and constructive. We have a good track record of collaboration across the north east and Cumbria and have worked with them to help develop our services. We are constantly seeking and getting feedback on what is working and how we can further improve. We appreciate the tough challenges they face and are here to support them.

6. What relationships do you have with other stakeholders?

As well as working with CCGs in our region we also have contracts with:

- > NHS England's area teams to provide health procurement advice, business intelligence and other services
- > Preston CCG, Chorley and South Ribble CCG and South Tees Foundation Trust to supply RAIDR, our business intelligence tool
- > CCGs in Anglia, Suffolk, Cambridge, Peterborough, and Great Yarmouth to provide Data Management Integration Centre (DMIC) services
- > Local authorities in the north east to provide ICT, BI and medicines optimisation services
- > Other CSUs to provide procurement and DMIC services.

7. What is your view on private sector involvement?

We are strongly committed to NHS values which reflect our own, but we are equally committed to providing the best we can to customers, as this ultimately benefits the patient and local healthcare.

If there are areas where we can offer more efficient and cost effective services that lead to better health outcomes by partnering with others, whether they are in the private, voluntary or public sector then this is the solution we'll develop.

8. What are the major challenges of working in a CSU?

Apart from the challenge of the transition that not just ourselves but also our customers have been going through, we know we need to prove ourselves very quickly – and in an uncertain and immature market. We are still adapting and developing but are now

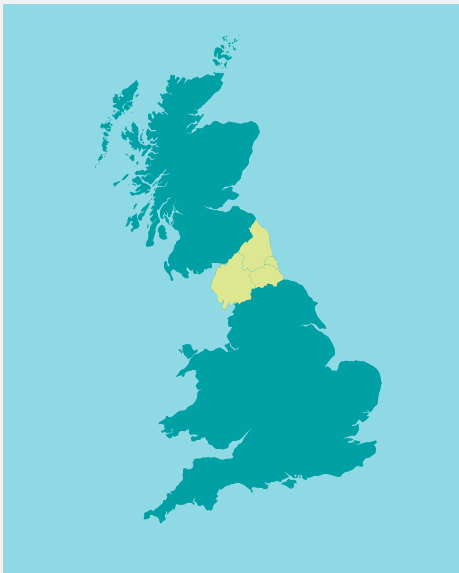
Facts and figures

Locations: Stockton, Durham City, Newcastle and Carlisle

CCGs

- > NHS South Tees CCG
- > NHS Hartlepoole and Stockton-on-Tees CCG
- > NHS Durham Dales, Easington and Sedgefield CCG
- > NHS Darlington CCG
- > NHS North Durham CCG
- > NHS Sunderland CCG
- > NHS South Tyneside CCG
- > NHS Gateshead CCG
- > NHS Newcastle North and East CCG
- > NHS Newcastle West CCG
- > NHS North Tyneside CCG
- > NHS Northumberland CCG
- > NHS Cumbria CCG

Patient population: 3.5 million
Percentage of income from CCGs: 71%



starting to see the positive results from our initial hard work and commitment.

9. Where do you see your CSU in 2016, post NHS England hosting?

We are working to understand our own business better so we can confidently become the ideal type of organisation should we become fully autonomous.

My personal wish is that NECS achieves its enormous potential to become an independent, sustainable business that ploughs profits back into improving services for customers, and ultimately patients – and is a business with a great reputation that the best people want to work for.

Biography

How does your career so far help you in your role as a CSU managing director?

I have been on a journey as a practice manager in South East London and a fund holding manager to my most recent post as interim chief executive of NHS Tees, a cluster containing four PCTs. I also led a community services provider organisation in South Tees before it transferred to a local acute Foundation Trust. As a practice manager, I came face-to-face with patients and I can fully understand the pressure GPs are under and what it means to commission care. All that experience has been perfect preparation for this role.



Why did you take on this role?

It's a unique challenge. Establishing a new business within the NHS and preparing it for the future is an extraordinary opportunity – and it's one which I, as an entrepreneur at heart, am very excited about.

Life outside the CSU: Getting to grips with planning rules as I attempt to modify my grade 2 listed house, chopping firewood and supporting Tottenham Hotspur.

NHS North West London

Commissioning Support Unit

Managing director: Sarah Whiting

1. What services do you provide?

We provide a range of commissioning and business support to clinical commissioning groups (CCGs) and directly to their practices. We've also built up our business with a range of contracts supporting NHS England, the Department of Health (DH), and others.

For NHS England, we're providing communications, freedom of information, and complaints services across London and the South of England regions as well as a national personal health budget delivery team. For the DH, we host the UK Genetics Testing Network.

In terms of CCG services, we're providing a full range of support including: commissioning support; business intelligence (BI); financial management; contracting and performance; procurement; joint commissioning; quality and safety; Individual funding requests; planned procedures with a threshold; medicines management; IT support to CCGs and GP practices; HR; communications and freedom of information.

2. How are you structured?

We've reviewed our operating model since we first launched and have reorganised ourselves into three business areas of accounts and sales; delivery and corporate. This has really

helped us focus on the different aspects of being a customer-focused and commercially astute business. It has clarified lines of accountability internally and is improving our operational discipline to ensure we're offering consistently high quality services and great value to our customers.

3. What regional challenges does your CSU face?

Our North West London CCGs have a very diverse population with some of the richest and poorest areas of London, and the health inequalities that come with that kind of divide. Locally, there is the service reconfiguration programme, *Shaping a Healthier Future*, which is the biggest of its kind in London and the big local opportunity to deliver better services for patients. That's moving into implementation phase now and is tied into out-of-hospital strategies and quality innovation productivity and prevention (QIPP) initiatives across the board.

With our NHS England accounts, we're working with a very different scale. The challenges across London and the South of England vary from one area team to another; but their need for expert advice and support on communications, freedom of information and complaints is consistent across all. Putting systems and processes in place has been a priority in the half of this year.

4. What are your strengths and weaknesses?

We've recruited a great mix of people with expertise and experience from across the NHS and other sectors; and our new operating model is a real strength. We've also appointed an Advisory Board, bringing in some really high calibre advisors from business and health related backgrounds, who are giving us a valuable external view on how we can develop and grow. The Board's Chairman is Sir John Chisholm and we have K.P. Doyle, Mark Rogerson, and Jeremy Monroe as members.

Working with our CCGs, we delivered a very good 2013/14 commissioning round; despite it being the most challenging financial backdrop from many years. We've also made some big improvements to key tools CCGs

need to commission effectively for which we've had a lot of positive feedback. Broadening our customer base with new services has also strengthened us as a business and will benefit our foundation CCGs as much as the new customers we've secured.

5. What are your relationships like with your CCGs?

We're all learning together and all have a lot of ambition to fix what's held PCTs back and address the challenges ahead. Relationships have changed a lot during the last 18 months as we all become much clearer about how the new system will work.

6. What relationships do you have with other stakeholders?

A lot. Local authorities within North West London are both a partner and customer in terms of the joint commissioning work we do. We're also working with them and CCGs on an integrated care pioneer bid, for which we've got through to the final shortlist from a field of over a 100 across the country. Our services for NHS England and the DH also bring us into a much wider circle of stakeholders across regional and national commissioning. And of course, the providers we work with on behalf of commissioners are a critical stakeholder.

7. What is your view on private sector involvement?

They have lots of skills and experience that commissioners could make use of, and we're expecting to see them enter the market more and more in the years ahead. We need to be able to see the opportunities to partner as well as the threats from competition. We're already seeing the benefits of advice and support from outside the NHS and believe partnerships with others could open up doors to essential expertise and improve the value of bringing in specialist support when it's needed.

8. What are the major challenges of working in a CSU?

There are new skill sets to learn for everyone across the organisation. We've been rolling out customer service training and there has been lots of work around establishing

Facts and figures

Location: Marylebone HQ, with staff on customer sites across London and South of England

CCGs

- > NHS Central London CCG
- > NHS West London CCG
- > NHS Hammersmith and Fulham CCG
- > NHS Hounslow CCG
- > NHS Brent CCG
- > NHS Ealing CCG
- > NHS Harrow CCG
- > NHS Hillingdon CCG

CCG Patient population: 1.9 million
Percentage of income from CCGs:
Undisclosed



systems and processes that are common place in established professional services organisations. Creating our identity and culture as a new organisation is crucial; but remains a challenge given there's still a lot of fluidity in the system.

9. Where do you see your CSU in 2016, post NHS England hosting?

We don't have any preconceptions about the right model for post NHS England hosting. We're starting to think about options, but bedding in and delivering on our current promises to customers has to be the priority at the moment. Our ambition is to be a thriving business with a great reputation for helping commissioners improve health for their patients; what organisational form we adopt to do that will unfold in the next 12/18 months.

Biography

How does your career so far help you in your role as a CSU managing director?

In previous roles, I was chief executive of the Inner North West London PCTs, and prior to that, managing director of Hammersmith and Fulham PCT. In both roles I have driven the integration of council and NHS commissioning. I have more than 18 years' experience in NHS commissioning and have led on the introduction of a range of high profile projects including, host PCT commissioning arrangements with major London acute hospitals, unscheduled care centres, a local primary care development programme called QOF+, and NHS 111 pilots.



Why did you take on this role?

It is a great opportunity to continue playing an important role in helping improve NHS services and the health of patients; while also being a chance to develop new skills for myself and all NWL's staff in a new kind of organisation.

Life outside the CSU: Gardening, my dogs and walking.

NHS North Yorkshire and Humber

Commissioning Support Unit

Managing director: Maddy Ruff

1. What services do you provide?

We provide the full range of commissioning support (CSSs) and business support services.

For commissioning support, we have experts across a variety of commissioning disciplines which we can call upon for clinical commissioning groups (CCGs) looking to redesign services. We have a team of people for strategic change which covers areas such as governance and medicines management. Our partnership with Attain means that we have a strong offer in terms of transformational management, and we are currently working with a number of CCGs on delivering major system changes.

On the business side we cover finance, workforce, planning, information management and technology (IMT), HR, corporate services, communications and engagement, procurement and market management. We have several new products. One covers how to respond to the Francis report and another is a directory of service for the new NHS111 non-urgent care telephone number. We are in talks with other commissioning support units (CSUs) about working in partnership on this directory for neighboring CCGs.

We also have a computer-based learning system (CBLS) which allows staff to undertake statutory and mandatory training without leaving their desk. This avoids the huge challenge faced by CCGs in releasing people to undertake training. All our CCGs are signed up and we are extending it to induction. We have been providing services since October.

2. How are you structured?

We have a leadership team which includes a director of business services, commissioning services, HR and governance, business development and marketing and a commercial director, who is from our partner, Attain.

We have four relationship managers, who are each responsible for two CCGs each. It's not a case of popping by for a cup of tea and a biscuit. We've been working with the CCGs to understand what kind of organisation they want to develop and how we can tailor our services to suit that need.

Since April, these managers have been embedded with CCGs. They spend 90% of their time at CCGs, and we have one corporate day on a Monday so people can meet and report back.

3. What regional challenges does your CSU face?

North Yorkshire is 5,000 square miles; it has very rural areas and vastly contrasting urban areas such as affluent Harrogate and Hull, where there are significant inequalities. The CCGs also have different financial challenges with the four North Yorkshire CCGs inheriting debts from the former primary care trust (PCTs).

There is also huge transformational change in the area. We are supporting North East Lincolnshire, and the four North Yorkshire CCGs with that, and we are talking to East Riding and Hull to support them with Attain.

The programme management office project teams are working on this. We also have our service delivery experts who work with individual CCGs on service redesign.

This is the direction we want to go in.

We'll offer really good business services to our CCGs, but we really feel we can add value in transformational service.

4. Where are your strengths and weaknesses?

I would say transformational change, clinical quality and HR and organisational development, where we are building up a bank of associates, are particular strengths.

It's something our CCGs want as they need support in building a new organisation and all that it involves, such as working through individual's values and how they are going to work as a team to ensure they meet their strategic aims. We have done a lot with some CCGs and we are aiming to get more work in this area in the future.

A big strength is that we had staff aligned in summer last year and were able to deliver services for the six months between October and April, so hopefully there wasn't too much of a disruption for our customers in April.

As for weaknesses, we are still in the early days, as are all CSUs. We are still learning and we will make mistakes. But when things are not quite as good as they could be, we have strong relationships with our customer to help us negotiate our way through.

We do need some clarity on the road map to externalisation and on what the relationship between the CSUs and NHS England will be.

5. What are your relationships like with your CCGs?

We have a positive collaboration with CCGs, and we have done a huge amount of work to make sure of this.

We carried out our first survey through Routeways in December, and it involved a questionnaire and some interviews. It found 70% would recommend us and 80% said we were responsive and collaborative.

We are pleased with that as we will use it to benchmark our progress when we carry out another survey in September. We intend to continue to do two surveys a year.

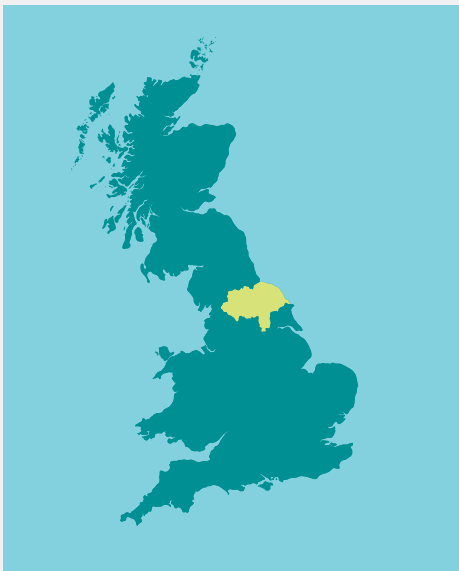
Facts and figures

Locations: Willerby in Humber and York in North Yorkshire

CCGs

- > NHS Hull CCG
- > NHS East Riding of Yorkshire CCG
- > NHS North East Lincolnshire CCG
- > NHS Vale of York CCG
- > NHS Harrogate and Rural District CCG
- > NHS Hambleton, Richmondshire and Whitby CCG
- > NHS Scarborough and Ryedale CCG
- > NHS North Lincolnshire CCG

Patient population: 1.7 million
Percentage of income from CCGs:
Undisclosed



6. What relationships do you have with other stakeholders?

We have a medicines management team supporting the process around quality, innovation, productivity and prevention (QIPP) and working with our dispensing practices of which there are quite a number.

We also provide medicines management to NHS Airedale, Wharfedale and Craven CCG and West Yorkshire CSU. We are talking to other CSUs about partnership working but nothing has been finalised yet.

We provide IMT to all the practices in our CCGs and to some hospitals including Humber NHS Foundation Trust, City Health Partnership Hull (CHCP) and Navigo and Care Plus, two social enterprises south of the Humber which provide community services.

We have met with our local authorities and they are keen to work with us although nothing has been agreed. We have met with the local medical committee, and we also produce a stakeholder newsletter on a monthly basis.

Once it becomes clearer what the CCG's strategic aims are, we'll be working with the voluntary sector to see if they have services which will align with commissioning plans.

We also work with North Yorkshire public health observatory on patient experience metrics and enhanced services activity.

7. What is your view on private sector involvement?

We have supported our staff using our partnership with Attain for the last 18 months. They are our commercial partners, helping to develop the commercial teams. We can call upon them when we need them, which adds value to our customers. We have worked with KPMG and its primary focus was to help us have a robust financial model and a commercial outlook. As we move forward, I envisage working regularly with other private organisation where there is added benefit.

8. What are the major challenges of working in a CSU?

The main challenge is to deliver a service to the specifications of our customers.

Our survival depends on whether we can

Biography

How does your career so far help you in your role as a CSU managing director?

In March 2011, I was appointed as executive director of commissioning development for the NHS Humber Cluster, before moving into the role of interim managing director for the North Yorkshire and Humber Commissioning Support Service in February 2012, a role for which I was confirmed May last year. I am very well known across North Yorkshire and Humber as I have worked in the area for 20 years and it's those relationships that are helping me. I have experience of commissioning, and so I understand the role that CCGs have taken on. I understand what it's like to be a commissioning leader and I think gives me credibility. I also have relationships with GPs and I understand primary care. I have experience in leadership management and inspiring people and building up a team.



Why did you take on this role?

I felt it was a challenge. I think we've got a big opportunity to be able to provide a whole range of commissioning support services and for CCGs to flourish. Lots of staff I talk to know how things can be so that patients benefit. So I hope we can drive that change.

Life outside the CSU: I am the unpaid driver and horse groom for my 18 year-old daughter who takes part in British Eventing. I also have a horse and I love walking my labrador and cocker spaniel in the countryside.

delight our customers. We want our services to be the highest quality, real value for money and continually innovating which is very different to any role I have had in the past.

9. Where do you see your CSU in 2016, post NHS England hosting?

It's hard to see what the model might be as it will be a very different landscape in 2016. Whether we'd be a joint venture, private sector or social enterprise is not clear and we are considering that.

We have set up in such a way that we are ready to break free from NHS England. But we need guidance and we await direction on that.

What I would say is that this organisation has a strong sense of social purpose that it's here to benefit patients.

NHS South

Commissioning Support Unit

Managing director: Keith Douglas

1. What services do you provide?

Our main service is provider relationship management, which draws together skills relating to contracting, business intelligence, finance and procurement. This ensures that our customers can be confident that their relationships with providers are supported by good processes and systems so that the care delivered is of the highest quality and efficiency. We support this service with a system reform/transformation offer sourced predominantly

through our wide range of partners from both the public and private sector; these partners include other commissioning support units (CSUs) who form the Elis Group. In addition, we provide communications and engagement, HR, ICT, interim placement sourcing, governance, leadership development, performance management, project management, quality and risk management.

We pride ourselves on our ability to work closely with our customers to provide a complete support solution. Many of our people have clinical backgrounds - including our directors - meaning that we have an in-depth understanding of clinical commissioning groups' (CCG) priorities. This enables us to work in a proactive and collaborative partnership, having evolved from a more traditional service supplier relationship.

team approach to provider relationship management, as well as the partnerships that we are developing with other CSUs via the Elis Group and other independent sector providers. We are excited that we will be able to offer a more in-depth service to clients in the future.

5. What are your relationships like with your CCGs?

Our relationships are strong and built on co-production of service offerings and constant review with our customers of what is going well, what is going less well and how we can improve. The relationships we have created and our operating model have allowed us to expand rapidly in the last four months; increasing our revenue and customer base by circa 30% since April 2013.

6. What relationships do you have with other stakeholders?

We do not constrain our desire to have strong relationships only to our customers. We maintain close links with other parts of NHS England, including local area teams and the Business Development Unit. We keep in touch with our local authority colleagues and indeed provide some services to them via our provider relationship management teams. We also keep in touch with our local medical committee which is important in helping us to understand the feeling on the ground from local GPs.

7. What is your view on private sector involvement?

We are proud of our position as an organisation that supports the commissioning and delivery of care to people. We believe firmly that it is irrelevant how an organisation gets its funding; more important is that the values that any organisation espouses and lives by are consistent with the NHS values. To that end, we are constantly looking for partners in both the private and public sector who want to help us as we support our customers to commission high-quality, cost-effective care.

8. What are the major challenges of working in a CSU?

It's very exciting to have the opportunity to work in this way. It has been a difficult period,

Facts and figures

Location: Eastleigh, Hampshire

CCGs

- > NHS Fareham and Gosport CCG
- > NHS Isle of Wight CCG
- > NHS North East Hampshire and Farnham CCG
- > NHS North Hampshire CCG
- > NHS Portsmouth CCG
- > NHS Southampton CCG
- > NHS South Eastern Hampshire CCG
- > NHS Surrey Downs CCG
- > NHS Surrey Heath CCG
- > NHS West Hampshire CCG
- > NHS Dorset CCG (out of Dorset contracts only)
- > NHS Milton Keynes CCG (ambulance contracting only)

From 1 October 2013:

- > NHS Brighton and Hove CCG
- > NHS Coastal West Sussex CCG
- > NHS Crawley CCG
- > NHS Horsham and Mid Sussex CCG
- > NHS Eastbourne, Hailsham & Seaford CCG (financial management and services only)
- > NHS Hastings and Rother CCG (financial management and services only)
- > NHS High Weald Lewes Havens CCG (financial services only)

Patient population: 3.7 million
Percentage of income from CCGs: 97%

2. How are you structured?

We use a matrix structure, with a team wrapped around each customer so that they have clear contact points at each level of the CSU. The teams work together, enabling clear communication internally, which leads to a more holistic service for customers.

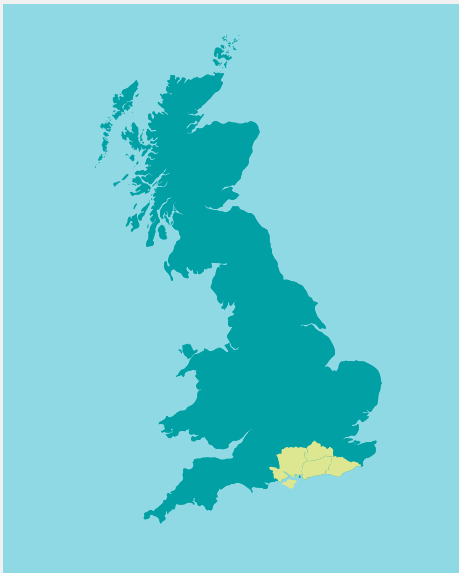
Our key mechanism is customer-facing teams. We have six directors, each with responsibility for one or more CCGs. All our directors liaise closely with clients, in addition to our team leaders and specialists, thus providing multiple points of contact for each customer.

3. What regional challenges does your CSU face?

Our key challenge is to support our customers in delivering high-quality, cost-effective healthcare. It is inevitable that as finances tighten, commissioners will need to consider how they can move providers to greater levels of integration to reduce the waste and bureaucracy created by multiple providers with differential payment mechanisms. We are positioning ourselves to support this process through our own direct skills and those of our partners.

4. What are your strengths and weaknesses?

We are very proud of our multi-disciplinary



setting up and shutting down primary care trusts, and supporting staff through the changes. People coming into the CSU need to recognise the new role we are in. Now we are working with CCGs, the decision-making bodies, we have to have a clear customer focus. Future autonomy means that a traditional, NHS methodology of working needs changing and updating: we have got to make sure our services are delivering properly.

9. Where do you see your CSU in 2016, post NHS England hosting?

That date is not particularly meaningful. What we are doing, regardless of hosting, is getting into a place where we retain the values and beliefs associated with delivering and supporting NHS care for people while looking like and feeling like a commercial organisation, and recognising that how we get revenue is by delivering a good service. What will be, will be, post hosting. We are reviewing internally and with our customers what vehicle would be most suitable for us to use as we exit hosting and it is likely we will take a decision on this in late 2013 or early 2014.

Biography

How does your career so far help you in your role as a CSU managing director?

I was a radiographer, and spent 20 years working in hospitals including Guy's and St Thomas', Carshalton and Redhill and Southampton.

I moved into general management of the radiology department and then into managing medicine and elderly care management, and finally orthopaedics in an acute hospital. I was director of contracting for the SHIP PCT cluster made up of Southampton, Hampshire, the Isle of Wight and Portsmouth.

I was then director of commissioning development at the cluster and moved quickly into the CSU from there.

The clinical background does help. It means I understand and can talk to clinicians at the right level. I do think it gives me an edge. I understand when to get tough and when to leave things be. I have also worked for the DoH for four years. I think more clinicians should be given the opportunity to work in management.

Why did you take on this role?

It's so interesting. I started very early with it and seeing it develop is really exciting. We are building a brand new form. It is not something I set out to do; I have evolved into this role.

Life outside the CSU: I love sport. I am a big football fan, and I support Liverpool. I play tennis and golf and enjoy spending time with my family.



NHS South London

Commissioning Support Unit

Managing director: Nick Relph

1. What services do you provide?

Our services are split into two groups; commissioning support services and business support services. Commissioning support services include acute contracting, individual funding requests (IRF) management, performance reporting and data management, financial management and planning, information tools, communications, medicine management, LES (locally enhanced service) management and support for adult continuing care. We work closely with our customers to develop these services and ensure they meet their needs.

The business support services group includes ICT, clinical procurement, support for community contracting, governance and quality, financial governance, HR and organisational development, non-clinical purchasing as well as estates management.

2. How are you structured?

We have a central team, three locally based

teams and some of our staff are embedded in our customer's offices.

That's what our customers wanted, for us to be local. That is important to us because our ambition is for all our staff to have a good sense of customer service, we want to make life as easy as possible for our customers.

3. What regional challenges does your CSU face?

The one that everyone will be familiar with is the situation in South London where the trust is in special administration.

Beyond that, there is the *Better Service, Better Value* programme in South West London which also impacts on some of our customers in Surrey.

4. What are your strengths and weaknesses?

I think the way we have built services for customers has given us a very loyal and strong customer base. We have not designed things and tried to sell them but have worked with the clinical commissioning groups (CCGs) as customers. As the third or fourth largest commissioning support unit (CSU), we have a strength in that we can work at scale and that's particularly helpful around some of the strategic challenges.

I am not sure about weaknesses – although I am clear that our biggest challenge is to deliver the quality of service that our customers need and deserve. We are working closely with our customers to find out what they need us to do to help them. Yes there are common issues across CCGs – but equally each one is unique and we need to understand how to make relationships successful.

5. What are your relationships like with your CCGs?

Good – and that's come out of our work over the last year, co-producing the services we offer rather than marketing or selling ourselves. As I have said, that's given us a loyal and strong customer base.

6. What relationships do you have with other stakeholders?

We meet regularly with the NHS England

and while there is a hugely challenging change programme underway, I have to say relationships are good and in positive shape.

We have made a start with the health and wellbeing boards and local government but that has not been our focus so far. There is no coherence of local government across South London, so there is no single voice we can talk to. And fundamentally, it is the CCGs that need to have the relationship with health and wellbeing boards.

7. What is your view on private sector involvement?

We have a few contracts with the private sector, in IT for example, where they are supporting infrastructure. We are open minded about partnerships of all descriptions, whether with the voluntary sector, other CSUs or the private sector. Our role is to get the best for our CCGs so wherever the best is, that's where we will look to work in partnership.

8. What are the major challenges of working in a CSU?

At the moment, it's all about doing the basic services and doing them exceptionally well. I am not sure that the NHS has a good record on shared services, but I do think that the CSUs are the right idea and a good bit of architecture. But if we do not get those very basic services right – if we do not deliver the acute contracts or the GP IT does not work – our lifespan will be limited.

9. Where do you see your CSU in 2016, post NHS England hosting?

I suspect that there will be some consolidation and that some niche players will emerge delivering specialist services. For example, there are functions such as communication around strategy that you do not need to do routinely, but when you do, you need high level skill. Why should all that expertise be in the private sector? There is an opportunity for some home grown expertise.

I think there will be a mixed market among CSUs. Some will be in the private sector and some will be social enterprises.

Ultimately, it will depend on the CCGs. We are certainly very clear that our future

Facts and figures

Location: Lambeth

CCGs

- > Bromley CCG
- > Bexley CCG
- > Croydon CCG
- > East Surrey CCG
- > Greenwich CCG
- > Guildford and Waverley CCG
- > Kingston CCG
- > Lambeth CCG
- > Lewisham CCG
- > Merton CCG
- > North West Surrey CCG
- > Richmond CCG
- > Southwark CCG
- > Sutton CCG
- > Wandsworth CCG

Patient population: 3.9 million
Percentage of income from CCGs:
Undisclosed



rests in discussion with our customers and any decisions have to be taken in conjunction with them.

Biography

How does your career so far help you in your role as a CSU managing director?

I am health through and through and have worked either inside the NHS or alongside the NHS for more than 30 years. My background is in accountancy, and the last six years, I have had a mixed background in the private sector and the NHS. My last role was as chief executive of three PCTs in North West London, and before that, I was chief executive of Thames Valley SHA. I have also worked as a non executive director for a private healthcare company – a role I no longer undertake in my current position. I think the combination of NHS experience and commercial experience is big plus. That and understanding the numbers and making sure the business is on a firm footing.



Why did you take on this role?

Joining the CSU was a very positive choice for me because I think that they are the right architecture for what we are trying to do in the health reforms and because I have the right background for the role.

Life outside the CSU: Walking and swimming to keep fit.

NHS South West

Commissioning Support Unit

Managing director: Jan Hull

1. What services do you provide?

We believe in putting customers at the heart of our business, and have structured our services to best deliver their needs. We provide end-to-end commissioning support services (CSSs) including business intelligence, IT, major reconfiguration and service redesign, commissioning strategy, provider management, contract management, clinical procurement, HR, finance and communications services, and a range of specialist services. Our services are flexible and responsive to our customers' individual needs and can be tailored to meet changing demands.

2. How are you structured?

We have an executive leadership team consisting of the managing director, a commercial director/chief finance officer, director of strategy and service transformation, director of business intelligence and informatics and a business solutions and innovation advisor.

To deliver our services, we operate a matrix model, and have put considerable effort into developing this, working with our staff and customers. We have functional teams, consisting of experts in their particular service area, and interwoven with this, we have delivery teams consisting of experts from different specialist areas working together to deliver to the customer.

Facts and figures

Locations: Central Bristol, Warmley in South Gloucestershire, Clevedon in North Somerset and Yeovil and Bridgwater in Somerset

CCGs

- > NHS Bristol CCG
- > NHS North Somerset CCG
- > NHS South Gloucestershire CCG
- > NHS Somerset CCG

Patient population: 1.4 million
Percentage of income from CCGs: undisclosed

Each of our customers has a relationship manager, who is responsible for the overall business relationship with that customer. This puts the clinical commissioning groups (CCGs) at the heart of our work, and enables us to truly work in partnership with them.

3. What regional challenges does your CSU face?

We have significant variation across the patient population. From rural sparsely populated areas in Somerset, to the diversity of black and minority ethnic populations and the high proportion of young people due to the many universities and colleges in and around Bristol. The strategic health needs of such diverse populations include issues of health deprivation and social care need, all requiring different commissioning solutions. In common with other regions we have a significant quality innovation productivity and prevention (QIPP) challenge.

4. What are your strengths and weaknesses?

Our strength is that we offer an end-to-end service, including a strong business intelligence service function. We are also one of the accredited data management and integration centres

We have a specific strength in the area of transformation and service redesign, and are actively involved in the commissioning management agenda to support our CCGs.

5. What are your relationships like with your CCGs?

We have worked hard to engage with our CCGs, and we feel that our relationship management structure is working well. We are challenging ourselves to do better all the time and have a focused programme of product improvement and innovation.

6. What relationships do you have with other stakeholders?

We have a contract with the NHS England area team for specialist commissioning, offender and dental health, and we provide IT services for some of the local community providers. We also host Smoke Free South West, the

team leading tobacco control initiatives in this area. We do have some contracts with local authorities around public health intelligence and are working to expand our business with local authorities.

7. What is your view on private sector involvement?

We have worked closely with external consultants in the creation of the commissioning support unit (CSU) and continue to do so in areas where we need to improve as an organisation.

The development of the commissioning support market over the next 12 months will be very interesting to watch, and I expect the private sector to have a significant role in this, although I think they will provide specialist, niche services as opposed to the end to end services that we offer. For example, business intelligence is a busy landscape where there is still an appetite in the private sector, and it will be interesting to see what will happen as the market develops.

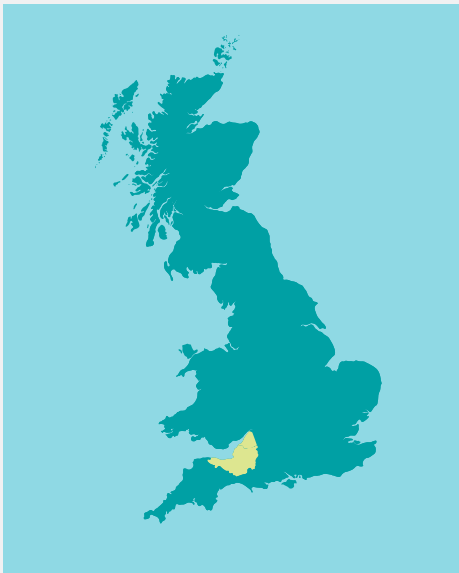
As a CSU we would consider opportunities to work in partnership with the private sector where it benefits our CCG customers and their patients. I believe there will be further consolidation of the NHS CSUs.

8. What are the major challenges of working in a CSU?

We continue to encourage our teams to embrace a more customer-focused culture while retaining public sector values. We have a talented workforce, respected by our CCGs, and are developing good business practices including resource management systems and performance frameworks to ensure we can deliver our services effectively. We continually strive for better, more innovative ways of working, to help us to deliver a real difference for our customers and their patients.

9. Where do you see your CSU in 2016, post NHS England hosting?

We are very positive about the future for SWCS and over the next 12 months expect to develop our plans for externalisation as the commissioning support market starts to mature.



Biography

How does your career so far help you in your role as a CSU managing director?

I was deputy chief executive and director of commissioning development in NHS Somerset which had a strong track record. So I understand the rigors of commissioning and the importance of clinical leadership and focus. I also spent six months in Somerset CCG as an interim accountable officer in 2011 which was invaluable experience.

I spent the first half of my career in sales and marketing in an international Unilever business and it has been great to be applying some of that experience in the CSU.



Why did you take on this role?

As the health reforms started to take shape I was drawn to developing a CSU as an area which was a good fit with my skills. Although it has been relentless in terms of the workload it is a close to a blank sheet of paper as you can get in the NHS and that is an exciting opportunity.

Life outside the CSU: I am married, with a daughter and son in their twenties. I enjoy entertaining and playing the flute.

NHS Staffordshire and Lancashire

Commissioning Support Unit

Managing director: Derek Kitchen

1. What services do you provide?

Business intelligence (BI), terms of engagement, continuing healthcare, contract management, corporate governance and legal, employment services, financial services, HR, IT, patient and public involvement and procurement.

2. How are you structured?

There are two separate commissioning support units (CSUs); Lancashire and Staffordshire, but there is a single executive team managing those two units. I generally tend to talk a bit like a holding company. That executive team has myself as managing director or a chief financial officer, depending on what title

you use. I have two delivery directors; one in Lancashire, one in Staffordshire, currently focused on each of the two counties.

We have an operating model that has three main components to it. They embedded staff that wear the CSU badge, and we are responsible for their pay and rations, and performance.

However, on a daily basis, they follow the guidance and the priorities set for them by the clinical commissioning group (CCG) in which they work, because there is a necessary face-to-face element of what we do with CCGs.

Behind that, there is what I call the consultancy service, so those people who are not based in CCGs, but travel and talk with CCGs on a very regular basis. Then there will be a transactional centre.

3. What regional challenges does your CSU face?

I think financially we can say calmly that everybody faces the challenges that quality innovation productivity and prevention (QIPP) 2 brings--so financially, enough said. This applies to all CCGs across the country, but obviously with being part of Staffordshire there is the response to Francis, and making sure that we support CCGs fully in ensuring that what led to the Francis Report does not happen again.

There are large areas, so you have got a full range of demographics both in terms of social mix, ethnic mix and levels of social deprivation. I would say that Staffordshire and Lancashire enjoy a pretty similar mix, to be honest. Nearly all the acute units in Lancashire, Staffordshire, Shropshire and Herefordshire face the same financial pressures.

4. What are your strengths and weaknesses?

Staffordshire's strength lies in the fact that it has been trading effectively for two years. We were set up very early within Staffordshire, so we have had the benefit of working with the CCGs now since April 2011. Effectively we were in shadow-trading mode for two years, but I would say we quasi-traded in 11/12.

The weakness that comes with that almost mirrors that success, and for me is two-

fold. One is that we were formed as quite a transactional support service, and we are now evolving into that transformational support unit. It would be unfair and wholly unwise of me to say that we have it right in all places, but I do think we are in a good place.

It is fair to say Lancashire was slow in its evolution.

5. What are your relationships like with your CCGs?

My view, which is supported by the various surveys that we get sight of, is that we have really good working relationships with CCGs. If I say personal, I mean very good personal working relationships with the accountable officers, the chairs and the CFOs. It is particularly true of Staffordshire, because obviously I have been there doing that for years. I would say the working relationship in Lancashire has built very, very quickly and very well.

6. What relationships do you have with other stakeholders?

In terms of the area team, I actually deal with three. The relationships are good and sound.

In terms of local authority, we are building that relationship, which therefore includes public health. There is a bit of an umbilical cord with public health because we were reliant on public health for input and vice versa. I cannot help my CCGs with commissioning plans if I do not know the epidemiology stuff that comes out of public health.

7. What is your view on private sector involvement?

I do not think we will grow unless we take in commercial advice and input, however that happens. As good as we are, and I think we are very good, we were not born as a commercial organisation, so we need to get that insight. We have worked with Staffordshire with Atos for the last two years on this.

We outsourced part of the financial modelling to Four Sight, a small company in the West Midlands which worked on the nuts and bolts of putting the specifics together, but financial planning has been done wholeheartedly by ourselves.

Facts and figures

Location: Staffordshire, in Newcastle-under-Lyme and Leyland, Lancashire

CCG customers:

Staffordshire

- > NHS Herefordshire CCG
- > NHS Shropshire CCG
- > NHS Telford and Wrekin CCG
- > NHS North Staffordshire CCG
- > NHS Stoke-on-Trent CCG
- > NHS Cannock CCG
- > NHS Stafford and surrounds CCG
- > NHS East Staffordshire CCG
- > NHS South East Staffordshire and Seisdon CCG

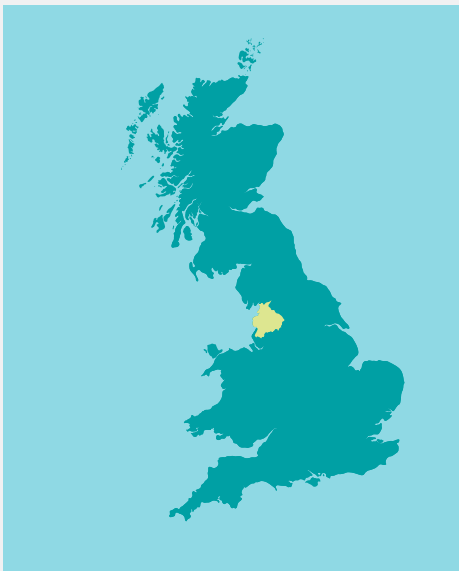
Lancashire

- > NHS North Lancashire CCG
- > NHS West Lancashire CCG
- > NHS East Lancashire CCG
- > NHS Blackpool CCG
- > NHS Fylde and Wyre CCG
- > NHS Chorley and South Ribble CCG
- > NHS Greater Preston CCG
- > NHS Blackburn with Darwen CCG

Combined patient population of CCGs:

Staffordshire 1.8 million Lancashire 1.9 million

Percentage of income from CCGs: 97%



In Lancashire, with KPMG, mirroring what Atos had done with us in terms of commercial thinking, but they also did some of the financial planning initially as well.

There are going to be companies out there that will compete with us. Do I believe that there is a non-NHS organisation that can do everything that we do as a CSU? No, I do not. Do I think there are non-NHS organisations that can do some of what we do better and cheaper? That is likely, but obviously that will be the technology related stuff in many respects. I could well see a situation where any one of the big houses competes with me in terms of business intelligence, but could also partner up with me in terms of business intelligence.

8. What are the major challenges of working in a CSU?

I do not think there are many, but bearing in mind that we are still bringing staff on, we will need to make sure that all of our staff very quickly get that 'we deliver what we promise' piece, and they fully realise the commercial environment in which we are working and how they need to react to that.

What we say to staff after April 1 is that CSUs will not have a natural right to exist in the NHS. So your hospitals, community nurses, community hospitals and mental health providers will always have that natural right to exist in people's hearts, including the politicians.

Now that commissioning has been completely redesigned as it has been, and is in the hands of GPs, the vast majority of the population who interface with the health service only ever see their GP. Let us not forget that.

Again, I think commissioning will grow big in the hearts of people and politicians. I am not sure many people will cry over the future of a CSU outside of the commissioning fraternity. While that might sound a bit dramatic and fatalist, it is actually meant to be realistic, and for me, it is the excitement of the challenge. If our staff get that, they will understand how they need to operate very quickly to ensure that we all have that right to exist. Our only right to exist is to delight our customers.

Biography

How does your career so far help you in your role as a CSU Managing director?

I joined the health service in 1986. I have been finance director and chief executive of Northern Birmingham Mental Health Trust. Prior to that I had varying levels of seniority in finance roles as I am a trained accountant.

I took five years out in the commercial sector and came back to North Staffordshire Primary Care Trust in 2008. I came back in as Performance Improvement Director. Then when we started to think about how the reform was going to work in Staffordshire, I decided that this is what I wanted to do, because I have always considered myself a change leader.

My wife would call me a change junkie if she was speaking to you. I have always taken stakeholders through change.



Why did you take on this role?

There are number of things I have done in my career where you had to take stakeholders with you for them to happen, and I include staff as stakeholders. So this just seemed a natural fit with that element of me, and also the commercial element to me. For me there was an element about doing what we now call commissioning support at that scale rather than 152 times, which is what the PCT was doing in the past.

Life outside the CSU: Family and golf.

9. Where do you see your CSU in 2016, post NHS CB hosting?

Quite genuinely, and I have been slightly criticised for this on occasion, I was more concerned about making sure we were fit for purpose than worry about the form of the organisation. If we do not delight our customers, then it does not really matter what we look like in externalisation because we will not be here. The classic models are there. Everybody talks about potentially three options, which are standalone, joint venture or private sector organisations. We are now part way through appraising those three options, and there is not much more value in me saying anything else on that one.

NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit

Managing director: Alison Hughes

1. What services do you provide?

We provide a wide range of commissioning and business support services for our customers, including:

- > Business intelligence (BI)
- > Data management and integration
- > Communications and engagement
- > Equality and diversity
- > Continuing healthcare
- > Personal health budgets
- > Financial services
- > Corporate, quality and information governance
- > Information technology (IT)
- > Medicines management
- > Procurement
- > Provider management
- > Transformation
- > Human Resources
- > Organisational development

We deliver these services for a wide range of customers including Clinical Commissioning Groups (CCGs), NHS England (nationally, regionally and locally), NHS provider trusts, local authorities and other non-NHS organisations.

2. How are you structured?

We recognise that great services are delivered by great people and we have a hugely talented and motivated team.

Our leadership team brings together a blend of commercial and NHS experience, ensuring that we remain true to our NHS values while we position our organisation to be successful in the emerging market for commissioning support services (CSSs).

We put customers at the heart of everything that we do. We have eight highly experienced customer relationship managers; these are critical roles in ensuring that we understand what matters most to our customers and that we are fully sighted on the challenges facing our CCGs.

Our customer relationship managers work with our customers and commissioning support unit (CSU) colleagues to enable bespoke solution development, acting as the voice of the customer into our service teams to challenge us to constantly raise our game.

3. What regional challenges does your CSU face?

Each CCG faces challenges in delivering improvements for their different populations, especially in this financial climate, and in addition, there are a number of financially challenged organisations across Yorkshire.

We cover a diverse population with huge health inequalities: from the rural Yorkshire Dales, to former mining towns; from some of Yorkshire's richest cities, to some of the poorest. There is no 'one size fits all'; there are no easy solutions, which is why we focus on innovation and problem solving.

4. What are your strengths and weaknesses?

Our strengths rest in our ability to leverage the benefits of at scale delivery whilst providing a bespoke, personalised service

to meet the unique requirements and circumstances of each customer. This is no easy task and we challenge one another every day to enhance our service delivery and improve our value proposition.

We have the knowledge and expertise to help to transform behaviours, systems and processes; the value-added piece that really makes a difference to our customers and, ultimately, to patients and local people.

Excellence is at the heart of everything we do, which is why we are on the path towards achieving Investors in Excellence standard – and why we are supporting a number of our customers to achieve it with us.

It is a huge challenge to bring together people from 10 or more organisations and we have worked and continue to work hard on developing a culture of openness, trust and relentless focus on quality. Our strength is in having a dedicated workforce who are absolutely up for the challenge and really want to make the new system work.

Commercialisation of our culture is also challenging. Some staff may think about commercial businesses as ruthless; the profit imperative taking precedence over other objectives; and this does not sit well with our NHS values to make best use of scarce NHS resources and improve care for patients. Yet there are fantastic values-driven organisations in the private sector.

It is not about ruthless commercialisation; it is about being a values-driven organisation that has a sustainable business model that enables us to grow and invest in the development of outstanding services and solutions for our commissioners.

The diverse experience of our leadership team puts us in a fantastic position to bring forward the best aspects of both worlds into the commissioning support of the future.

5. What are your relationships like with your CCGs?

We want to build long-term relationships with our customers based on trust and aligned objectives. We benefit from hugely positive and supportive local CCGs and work hard to ensure that we continue to develop and keep

Facts and figures

Location: Bradford (HQ)

CCGs

- > NHS Airedale, Wharfedale and Craven CCG
- > NHS Bradford Districts CCG
- > NHS Bradford City CCG
- > NHS Calderdale CCG
- > NHS Greater Huddersfield CCG
- > NHS North Kirklees CCG
- > NHS Leeds North CCG
- > NHS Leeds South and East CCG
- > NHS Leeds West CCG
- > NHS Wakefield CCG
- > NHS Rotherham CCG
- > NHS Doncaster CCG
- > NHS Bassetlaw CCG
- > NHS Sheffield CCG
- > NHS Barnsley CCG

(These are the main CCGs for whom we are the primary provider of CSSs. We work with a number of other CCGs, and NHS and non-NHS organisations.)

Patient population: 3.6 million

Percentage of income from CCGs: 55%



pace with their rising expectations - so that we are one step ahead, bringing forward the solutions to tomorrow's problems today.

Our CCGs want to make things work. They have given us more work beyond our initial contracts. Our relationships are strong but undoubtedly will be tested during the coming months as we go into the contracting round and local services come under increased pressure. However, our lines of communication with each other are strong and we are able to be honest with each other.

6. What relationships do you have with other stakeholders?

We have very positive relationships with other stakeholders. In today's more fragmented commissioning landscape, we have an opportunity to bring people together across the local health economy to develop solutions to the wicked problems that we face and build consensus.

We deliver services for NHS England both locally (for the West Yorkshire and South Yorkshire and Bassetlaw Area Teams) and nationally; we have contracts with a number of local provider trusts.

We are also engaged with a wide variety of other organisations, from local authorities to business organisations and local and national charities.

7. What is your view on private sector involvement?

Our mission is to delight our customers by delivering outstanding commissioning support so that we enable them to be successful and to make a positive difference to health and wellbeing in our local communities.

We are committed to working with partners and suppliers to access the best possible support. We have relationships with a number of providers in our supply chain in areas such as Transformation, Organisational Development and Business Intelligence.

By working innovatively and collaboratively with other CSUs and with NHS, private sector and third sector organisations, we will enable our CCGs to deliver transformational change in our local health economy and improve the health and

Biography

How does your career so far help you in your role as a CSU managing director?

I started life as a physiotherapist and spent 10 years working clinically. I have had a number of managerial roles in acute trusts, the SHA and the PCT. My most recent post was for Yorkshire and Humber Strategic Health Authority, working on the foundation trust pipeline. This career path has given me fantastic knowledge about all parts of the NHS. I have always been 'intrapreneurial', I have always looked for opportunities to do things differently and lead teams that focus on people's strengths and capabilities in order to improve services for staff and patients.



Why did you take on this role?

It's my ideal job. To set up a new solution-orientated organisation that brings the best of what the NHS, third sector and private sector together can do fits with my passion for delivering real changes for patients. As a CSU we can innovate and bring new and different solutions to our customers. We are able to deliver change on a big scale.

One of my aims is to employ truly great people and to be in the The Sunday Times top 100 employers list. I have always wanted to lead such an organisation. Why shouldn't an NHS organisation be a top employer? Great staff deliver outstanding solutions that delight customers.

Life outside the CSU: Sailing, gardening and cycling.

wellbeing of local people.

We see it as our job to have a relationship with, and contracts with, lots of different organisations. It is our job to know where the best services are for customers, and where appropriate, we will bring in other organisations to deliver for them.

8. What are the major challenges of working in a CSU?

Our major challenge is to ensure that we support our customers to enable them to deliver their outcomes in an increasingly constrained financial environment.

Customer focus is everything; without our customers we have nothing. We have to be responsive to what they are asking us to deliver. But over and above that, we must delight our customers in order to succeed. To do this, we need to build trust. We need to be a flexible, efficient and responsive organisation that anticipates our customers' needs.

9. Where do you see your CSU in 2016, post NHS England hosting?

There are going to be a number of options for CSUs and we are actively engaged in an open and honest dialogue with our customers and other stakeholders, recognising the relationships and interdependencies that will be fundamental in enabling us to be successful together.

Our immediate focus is to ensure that we deliver for our customers; that we offer great value for money, bring forward innovative solutions to the problems that they face, develop successful partnerships to deliver at scale efficiencies and successfully get on to the Lead Provider Framework for commissioning support services providers so that in the coming years our customers can access our services efficiently and cost-effectively,



Section 2

Independent sector
providers

Independent Sector Provider

Partner (Health): Elaine Bennett

1. What CSSs will you provide over the next 12 months?

Our services will include supporting clinical commissioning groups (CCGs) with operational excellence, commercial awareness, financial management, organisational design and development, and business intelligence/IT.

The components to the above include:

- > Developing commercial leaders
- > Undertaking market/competitor analysis
- > Designing optimum business architecture, functioning and enablers
- > Workforce modelling, transition planning and analysis of roles and responsibilities required to deliver target operating models
- > Evaluating governance arrangements, performance and management processes throughout the organisation
- > Carrying out 'voice of customer' exercises and benchmarking best practice processes across sectors to develop process design and improvement programmes

Our support programme is informed by an extensive range of commissioning support assignments, previously delivered including:

- > Designing and implementing organisation-wide performance management frameworks, ranging from data collection and reporting systems to development of meeting structures and coaching
- > Developing and facilitating a programme of process redesign workshops, involving

a full current state process review, waste elimination and future state design

- > Developing a commercial strategy for commissioning support units (CSUs) with a clearly defined, structured growth plan

2. How is your business structured?

Atos is an international information technology services company serving a global client base, delivering hi-tech transactional, consulting and technology services, systems integration and managed services. Atos is focused on business technology that powers progress and helps organisations to create their 'firm of the future'. CSUs can engage with Atos across our spectrum of support, to position themselves as leading organisations in their field.

3. What is different about your organisation, and why should commissioning organisations come to you?

Firstly, our work has been recognised: Atos Consulting won this year's prestigious Management Consultancies Association Award for change management in the public sector, for its work with NHS Staffordshire CSU.

Secondly, our work is appreciated by our clients: 'The ATOS team's balance of first class commercial acumen and in-depth knowledge of the local health economy, together with their integrated approach to team working has been instrumental in Staffordshire CSU's rapid

development since February of this year.'

Derek Kitchen, Managing Director, Staffordshire and Lancashire CSU.

Thirdly, we have been a regular supplier to the health and social care sectors both in the UK and across the globe. Our global experience gives us further insight into different and innovative ways of working which we are able to draw on and share with our customers. In the UK, our work with the NHS ranges from wholesale service transformation, developing and running key systems to delivering health and wellbeing medical and clinical services.

Fourthly, we combine our global IT services capability with a health consulting practice that has over 25 years of experience working with health organisations, delivering efficiencies and improving patient outcomes. We are in a digital age, and as an IT company we are able to help our clients transform and digitise services starting from the business case to deployment of the technology and running the service.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

The familiar challenges of commissioning include how to enhance patient outcomes and quality of care, with increasing demand, reduction in real budgets and increased costs.

To meet these challenges, CCGs will need to focus on making informed and timely commissioning decisions. CSUs can help CCGs by providing excellent support services that enhance CCGs' ability to make these decisions and correspondingly transform services. For example, where CCGs do not have the capacity to deal with all of the contract management and the processing, CSUs will provide an invaluable transactional service. In addition, information can add value as it is a key enabler for commissioners, and CSUs should be looking to provide both the tools and the expertise to help commissioners make brave and informed decisions. They should support innovation and be proactive in bringing new ideas to CCGs to enable service transformation. CSUs will need to constantly evolve, provide value for money and enhance offerings to maintain and extend contracts and reach.

Facts and figures

Number of dedicated staff in the healthcare team: 74,000 employees in 42 countries
Current CCG, CSU and other NHS customers: Central Midlands CSU, Staffordshire and Lancashire CSU, West Yorkshire CSU; DH; NHS Scotland; GP practices

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: organisational development, financial modelling, commercial strategy development, business process assurance and operating model development, IT and informatics review, business strategy and planning, development of Go to market solutions for new products, SLA development; wholesale service transformation; developing and running key systems; delivering health and wellbeing medical and clinical services; delivery of medical and clinical services including disability assessment for the Department of Work and Pensions

Main competitors: undisclosed

5. What partnerships or planned partnerships do you have? Who does your network include?

Our partnerships are purposeful and targeted, and our network is extensive ranging from large multi-nationals to specialist local small and medium enterprises. We continuously evaluate the need for partners.

We also form long-term partnerships with clients to deliver services together. For example we have been the IT partner of choice to the International Olympic Committee (IOC) for the past 20 years. The most recent Olympics, in London, were our most connected and digital yet, with 8.5 billion devices, 4 billion TV viewers, 27,000 broadcasters. This was delivered through collaboration with multiple technology and other service providers including Acer, Panasonic, Samsung, BT and Ticketmaster.

Other collaborative alliances include:

- > We have a long term partnership with IBM as part of the Atos Alliance with NHS Scotland
- > In the Netherlands, for ORBIS, one of the biggest healthcare providers in the country, Atos designed and built the complete digital hospital using our own concepts for infrastructure, telephony, bedside terminals, nurse-call system, identity and access management, patient self-check-in
- > In South America, our systems validate, administer and monitor the cost of medical intervention for 6.5 million privately insured patients, managing 4.5 million transactions at over 12,000 pharmacies

6. What are the major challenges of working as a provider of CSSs?

The uncertainty over the future provision of CSSs makes it difficult in a number of ways:

- > CCGs and CSUs feel less able to form long term strategic partnerships of over five years;
- > Public and private sector investment becomes more difficult
- > Commissioning focus can be short-term, rather than longer term outcome focused, which is a particular challenge for CCGs but also impacts CSUs seeking to provide transformational support.

In addition, the 'market' for CSSs is immature and the buyer landscape is fluid, making it difficult for anyone wishing to provide services.

Biography

How does your career so far help you in working with the NHS?

I have 20 years' experience of working in the health sector – ten years in Healthcare Consultancy and previously ten years in NHS management positions, including three Commissioning Chief Executive roles and a Director in an acute hospital. This experience provides a helpful frame of reference, alongside more formal qualifications I have obtained, such as an MBA from Henley Management College and a coaching qualification.



What attracted you to working in this area?

I had an interest in the health sector and a fascination with its achievements from a young age. While at University in Dublin, I became aware of the NHS General Management Training Scheme. I recall putting huge effort into securing a place on the training scheme, flying over to Liverpool on a number of occasions, including visiting Alder Hey Children's Hospital to understand more about the workings of a hospital. 20 years on, the fascination continues. It has been very rewarding to have been involved in the planning and delivery of improvements in the health service.

What do you enjoy doing outside of work?

I am a keen ballroom dancer and have danced competitively in the past. I also enjoy playing the flute and hosting large parties, a few times a year. I am currently chair of the local Residents Association. I am married with two sons, aged eight and six.

7. How do you see the CS market evolving?

There will be more reliance on effective decision-making based on data. It is likely to be a priority for CCGs to access accurate, timely data that provides citizen-level understanding, both at the regional and national level.

Consideration will need to be given to scale versus the need for flexibility and variety, as determined by local need. Getting the right balance will be important, including the key interface with specialised commissioning.

Integration is high on the agenda, adding a further dimension to solutions and support required. Multi-disciplinary and integrated teams involving clinicians, social care and the voluntary sector as a way to resolve the demand on urgent care will require commissioners to be aware of the capacity across the health economy, including beds, social care packages, access to nursing homes while understanding the alternatives available. Although not a new requirement, being fully informed as a commissioner is of paramount importance with the increased pressure on the system. 'Big data' and citizen-level

understanding of what is available will really enable better decision-making. Commissioning for outcomes is what all commissioners aspire to. Despite continual progress, there is still much to be achieved.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

We are always interested in exploring how we can best support our clients and so at this stage we would be interested in leading or partnering to deliver such services. Atos has significant experience of operating contracts which follow the principles of Alliance Contracting, such as, common outcomes, shared risk and gain, and leading and operating with companies and organisations which share a direct relationship with the customer.

Independent Sector Provider

Managing director: Mark Carmichael

1. What CSSs will you provide over the next 12 months?

We are focused on those services that transform healthcare – service transformation, procurement of clinical services, contract and provider management and we also support clinical commissioning groups (CCGs) to operate as high-performing commissioning organisations.

We do not expect this to change fundamentally in the long term; it's what we do best and we believe that these services are vital to effectively integrate care services, meet growing demand and balance the books.

2. How is your business structured?

Attain was formed in January 2011 with the sole focus of delivering healthcare commissioning support for the NHS.

We are structured on a matrix. On the vertical, we have four service lines of technical capability: service transformation, procurement of clinical services, contract and provider management and strategy and commissioning development. On the horizontal, we focus on end-to-end solutions for specific care areas such as out-of-hospital, mental health, unscheduled care and continuing healthcare. We can either provide a functional solution, for example, providing an embedded procurement service for CCGs in the East Midlands. Or, we can provide an end-to-end solution by helping a CCG move services out of hospital.

3. What is different about your organisation, and why should commissioning organisations come to you?

Firstly, commissioning support is all we do; it's our sole focus. Unlike others, commissioning support is not a division or a business unit within something else; it's our whole organisation. We have built our organisation from scratch solely with providing commissioning support services (CSSs) for the NHS in mind. We are a market leader in the provision of CSSs and have a national footprint; working with 28 CCGs.

Secondly, we take responsibility for delivery. While we have a great track record of strategic planning and design we really want to get on with the doing and implementing; we are not 'consultants'. We are driven by a common desire to make a real difference in the NHS for patients. We don't 'cherry-pick' and have a strong appetite for tough programmes.

Thirdly, customers have consistently cited our values as a key factor that sets us apart. This allows us to work in true partnership with the NHS. We have always maintained a profit cap of 12% and will continue to do so. Also, our ownership model is one where we are staff owned with wide employee share ownership. This has been tremendous in terms of the people we are able to attract to Attain and the alignment of incentives in terms of how we add value.

We have a high calibre of staff and we have been very successful in recruiting people

from a wide variety of backgrounds--NHS provider, NHS commissioner, private sector healthcare plus really good, strong project delivery people and individuals from the commercial sector with strong commercial skills and the right values set.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

The challenges that NHS commissioners face are well documented. The challenge is to deliver safe and effective care in an environment where the cash is flat and the level of demand is going up. In terms of the service we provide, we have a great track record of delivering actual transformation to how care is delivered and this is going to be really valuable to commissioners and patients going forward.

In terms of the relevance of our services then we are (and will continue to be) uniquely focused on providing transformational commissioning support to drive improvements for patients. Examples of our recent work include:

- > Supporting the transformation and integration of services across health and social care in geographies such as East Riding, Hull and York
- > Developing new services outside of hospital including: integrated care teams and models of care, intermediate care, referral management, telehealth, community geriatrician services and the development of primary care
- > Transforming mental health services across the adult population of Wales – improving quality and safeguarding while reducing expenditure by over £5million
- > Procuring front-line clinical services in a way that demonstrates the ability to make CCGs' commissioning intentions a reality
- > Delivering successful contracting rounds for CCGs in relation to mental health and Community Services.

5. What partnerships or planned partnerships do you have? Who does your network include?

We are working in partnership with two

Facts and figures

Number of dedicated staff in the healthcare team: 50

Current CCG, CSU and other NHS customers: 28 CCGs, 2 CSUs, 4 local authorities

Percentage of income from NHS contracts: 100%

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: 100%

Service coverage/types of service provided: Solely focused on commissioning support services: service transformation, procurement of clinical services, contract and provider management and strategy and commissioning development

Main competitors: We compete against a broad spectrum. Large outsourcing companies, the Big Four accountancy firms in terms of consultancies and individual interims in areas like contract and provider management

commissioning support units (CSUs) – North Yorkshire and Humber and Central Eastern and will seek to continue to work in partnership with a small number of CSUs going forward. To date, we have not felt the need to partner with other independent sector providers of commissioning support. However, we continue to hold regular discussions with others in our market regarding opportunities to collaborate.

6. What are the major challenges of working as a provider of CSSs?

To transform care CCGs will need access to people who can be a conduit for best practice and are ‘deliverers’ not ‘consultants’. Our customers have cited our strengths as including the ability to be agile and responsive within a changing environment and the fact that we take the time to really get to know each customer organisation and its specific challenges. As we continue to grow, we will need to maintain our focus to ensure we continue to do these things; they are a key part of what sets us apart.

Other independent providers have expressed a view that they have, historically, found the lack of clarity around the future development of the CSS market frustrating. We view this a bit differently. This has been a fact of life for us since our formation in January 2011, and we have demonstrated a willingness to proactively work with CCGs to understand the support they require in detail and ensure that they have this in place.

7. How do you see the CSS market evolving?

I think transactional or back-office services, clinically led support services and transformational commissioning support services, will develop differently. In transactional services there will inevitably be a drive for scale and consolidation in order to get efficiencies. Paradoxically, I think there will be a drive for localisation for the others. CCGs will want to keep clinically led services such as continuing health care, medicines management and quality closer to them and they will want to keep transformational services such as those provided by us close to

Biography

How does your career so far help you in working with the NHS?

I am one of the three founders of the organisation and I have been in post since Attain's formation in January 2011. I started in health ten years ago when I was with KPMG Consulting briefly working with acute sector providers. I then joined a values-based start-up called Avail which grew to an organisation of more than 60 and led their health commissioning team. Prior to working in Health I spent six years in operational roles in manufacturing industry with Honda and Unipart. If I look back, my roles have highlighted the importance of an evidence base to bring conviction to decisions and the importance of relationships. I think now, more than ever, if you are really going to make major changes in health, the most important currency is relationships, in terms of getting change implemented and for it to stick. Clearly this needs to be backed with operational delivery at pace.



What attracted you to working in this area?

I have always had a passion for healthcare, which is why I have spent the majority of my career in health. In terms of Attain specifically and why we started it, it really was about the private sector making a difference for patients. Helping commissioning deliver new services and changes for the benefit of patients, working with a group of people who have the same passion for healthcare, the same ethos, and being able to build something unique from a blank sheet which is exactly what we have done.

What do you enjoy doing outside of work?

I enjoy being outdoors - cycling, mountain biking and walking – and am planning to cycle from Anglesey to Cardiff next spring. Also cooking and spending time with the family.

them as well. They could bring these in house or look to have them delivered in partnership by mixed NHS and partner teams.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

I understand that the framework is to be based upon a lead provider model with the ‘lead’ providing access to both back office support services and some transformational services. Attain has a very clear purpose which does not include the provision of back-office support. We would therefore seek to continue to provide our services through a combination of partnering with a small number of CSUs and direct provision to CCGs.

Bain & Company

Independent Sector Provider

Head of healthcare in the UK: Dr Christian Mazzi

1. What CSSs will you provide over the next 12 months?

We help commissioners define their strategy – looking at how and where they should focus their scarce resources – and effective organisational design. We have a way of thinking called decision-driven organisation where we take decisions as the centre point and ask: ‘What are the top ten to 15 decisions you have to make as a commissioner on a day-to-day basis?’ and build the organisation around that. We can also help with integrated care including building services around the patient, understanding the journey that the patient goes through, what services are involved and how they should be linked together. We then, where possible, translate that into a tender that you can then go to market with. We have a real sense of what the private sector has to offer, because we do so much work in that space; and that is often an area that commissioners do not have a good sense of. One of the areas of strength that we have is performance improvement, which is basically driving efficiency out of your process, your people and your costs and procurement.

2. How is your business structured?

Bain & Company is a management consulting firm offering advice to leaders on strategy, marketing, organisation, operations, IT and mergers and acquisitions, across all industries and geographies. Our teams are set up to understand what the client wants, what support they will most value and what analysis is going to be required to give the best answer and make sure the required changes happens.

If there is an implementation need, we are happy to roll up our sleeves and help and then make sure it stays in place. We will set ourselves up to bring the right people in from third parties rather than put in a huge cost of people from our own organisation as we think it would affect our ability to give impartial advice.

3. What is different about your organisation, and why should commissioning organisations come to you?

Generally speaking, at the highest level, our clients tell us that what sets us apart is our focus on results. Our mantra is we work with action-oriented executives that are looking for change. We want to be comfortable and confident that who we are working for is in a position to drive change, because we will often willingly put our fees at risk on the basis of the result that is achieved. That comes with a differentiator around being very practical and value-focused rather than focusing on the theoretical.

We are international so one of the things we bring to the table is a perspective of what works in different countries, but also in different industries, which in healthcare we find is a relatively useful perspective to bring to the table, where a lot of lessons learned come from other industries that have gone through transformations and have benefited for several years, if not decades, of being ahead of the curve in some of the aspects.

For example, we worked on a mental health model originally developed in Germany,

which was piloted in the UK for schizophrenic patients where all the risks of managing the patients were transferred to provider and savings on delivering the results were then divided between the commissioners and the provider. Also, at the moment, we probably have the best sense of what the commissioning landscape looks like and the relative level of maturity of the commissioners.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

One of the biggest challenges is getting value for money, unsurprisingly. The undertone to that is, how do you measure the outcome that you are actually getting, and then do you have the right information, the right outcomes structure upfront so that you can make the right choices and then validate the choices in terms of who you choose to commission with? Equally, I think one other big challenge is understanding what the alternatives are. Some commissioners may just not have the visibility or the experience to understand what market offer is for any given type of service. Then frankly, probably the biggest challenge is the way purchasing is going to be done in the future is going to be very different from the past. Historically, I would have paid you on the basis of you delivering a commissioned service but tomorrow, it will be on the basis of you delivering certain outcomes. But how do I even structure or agree that these are the outcomes that I am going to look for? How do I even set up the information systems to make sure that we have the right outcome, the right information to then pay you or not pay you on that basis? How do I create the payment so that it is clear for everybody and it creates value for the system and the patient?

5. What partnerships or planned partnerships do you have? Who does your network include?

We often collaborate with different partners across the healthcare value chain to create innovative services relevant for clinical commissioning groups (CCGs). For example, we recently collaborated to develop a service for early discharge in orthopaedic surgery

Facts and figures

Number of dedicated staff in the healthcare team: undisclosed

Current CCG customers: undisclosed

Current CSU and other NHS customers: undisclosed

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: strategy, performance improvement, organisational design/performance, mergers & acquisitions

Main competitors: undisclosed

that uses new protocols and technologies to improve outcomes and reduce costs.

6. What are the major challenges of working as a provider of CSSs?

It is just the very different levels of maturity with regards to how clear commissioners are about their strategies and what they intend to do with their new responsibilities and the structures they have in place to do that. From our perspective, the most difficult thing is identifying which commissioners are in the position to have those conversations, which will benefit from a different view from other countries or other systems and are willing to make the investment. Although our results are a significant multiple of our fees, our fees represent a significant investment and that will remain a challenge. You have to have a very different way of thinking about our services in terms of the value they create, not so much how much they cost. Again, we are willing to make that easy in terms of putting fees at risk against that value, but it is still a considerable investment, and that will remain a challenge for a long time.

7. How do you see the CSS market evolving?

I think it really depends on policy, but it is a real opportunity. I think the private sector has the ability to become the alternative, assuming that there are the right outcomes in place and metrics for measuring the performance, and that they are willing to put some of their fees at risk, in terms of delivering the results using innovative models and there is a real opportunity there for the commissioners to tap into that. I think the private sector will grow significantly. This is however dependent on how quickly CCGs mature in terms of their awareness that new ways of commissioning are required and how clear they are about their strategies and how they are going to use their new responsibilities and whether they have structures in place to do that. I think the commissioners are also going to become more sophisticated in understanding where scale matters and how it can be used which will drive the CSS market.

Biography

How does your career so far help you in working with the NHS?

I started my career as a physician and then transitioned to healthcare consulting. I have practiced and worked in diverse markets like US, Australia, France, Italy, Spain, Brazil, Australia, and Russia. What has prepared me is the fact that I have seen very, very different systems of delivering care, and can bring a sense of what works and what does not, and what is best practice out there, as well as an interpretation of what could or could not work in the UK.



What attracted you to working in this area?

As a physician, there was a sense of frustration from how inefficient patient care was. I was spending 40% of my time as a physician doing admin instead of patient care. I also felt that there was a huge lack of communication and efficiency because of how siloed the patient journey was. I was seeing patients and I had no idea what their previous care looked like and why they were in a particular situation. There is a huge opportunity to improve the way care is coordinated around the patient's journey. That is part of the motivation, and I feel like we can improve that.

What do you enjoy doing outside of work?

I like flying light aircraft and spending time with my two young daughters.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

The answer to that question is yes, but only after having worked with the CCG on their strategy to make sure that they are actually headed in the right direction and they are thinking about commissioning in the right way with the right metrics, the right outcomes to be measured for, that they set up the tender correctly. We'd also be happy to partner if that was the right thing to do for the client.

Boston Consulting Group

Independent Sector Provider

Director of health services: **Graham Rich**

1. What CSSs will you provide over the next 12 months?

A key part of what we do is change management and using data to understand problems and inform decisionmaking. We are currently doing work with a health economy around changing the nature of services on its patch to improve quality and make it more sustainable. This means changes in secondary care, primary care and intermediate care. So, we expect that type of work to be in demand over the next 12 months.

We also expect work around clinical reconfiguration in health economies, looking at how you move services around and what makes sense. We are happy to work on other areas particularly around reviews of services.

2. How is your business structured?

The Boston Consulting Group (BCG) is a global management consulting firm and a leading advisor on business strategy.

We have about 10 ex-clinicians on staff and a couple of hospital managers, so we have people with deep clinical managerial expertise and we also use other people that have different backgrounds that work on healthcare.

We have a flexible staffing model, so although we have got a core healthcare practice, an NHS practice, we often bring in other people with other particular skills,

whether it be modelling, statistics, maths, whatever we are looking for; we might bring in people with other types of experience to solve particular problems. We tend to have small senior teams that are skilled across a number of areas, bringing in people with different expertise as required.

3. What is different about your organisation, and why should commissioning organisations come to you?

We pride ourselves in working with our clients rather than just giving people the answer. Part of our culture is to actually help our clients work through the answer and ensure that in the future they will be better able to solve the next problem that comes along without us. With that in mind, we try and focus on empowering our clients by building their skills. We do presentations, facilitate workshops or get people around a table to discuss a common problem. We have got very talented people working for us, and most people enjoy working with us.

Another major issue for us is our focus on getting the change delivered and making a difference to the end user at the same or lower the cost. We work internationally on value-based healthcare and are part of a non-profit collaboration with the Harvard and the Karolinska Institute to encourage use of outcome measurement in healthcare.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

Well, they face multiple challenges. There will be tough economic times for the foreseeable future, and so the focus on resources will get tighter and tighter.

I think the challenges around making sure that services are integrated across social care and healthcare is going to be a major issue. Looking for ways to encourage the service to become more patient-centric, more focused on value is important.

There are challenges around getting major strategic change to happen, given that we no longer have strategic health authorities in place that oversaw a lot of those big changes in the past. So, commissioners now need to work together across clinical commissioning group (CCG) boundaries in order to deliver major service change where it makes sense for patients. I think that is one of the challenges.

Some CCGs are relatively small, and they may not have all the expertise within their team in order to be able to carry out all the things that they need to do.

While commissioning support units (CSUs) can help with that, they may not engage in some of the strategic change programmes that may be necessary. Someone within a CSU may get involved in a major service change once or twice in their professional career, whereas at firms like ours, it is what we do all the time.

We work around the country on these projects and we get experience, and we can use best practice from other places. However, CSUs have got the benefit of some scale and they have got benefit of a range of different specialities.

They have got access to good information and analytic support, so they are well placed to help with contract management monitoring. They have enough people to have specialists in particular areas, including communications, but also service leads in mental health for example. So they are large enough to support the CCGs in that respect.

Facts and figures

Number of dedicated staff in the healthcare team: 4 partners and a flexible workforce deployed according to demand

Current CCG, CSU and other NHS customers: North Lincolnshire CCG and North East Lincolnshire CCG

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: Support for transformational change, clinical reconfiguration, sustainability of services, improving efficiency, applying a value based approach to healthcare, pathway redesign, clinical and stakeholder engagement, strategy, organisational design and development and using data to inform decision making

Main competitors: undisclosed

5. What partnerships or planned partnerships do you have? Who does your network include?

We do not have any partnership at the moment with other firms, but we are talking to a number of CSUs. It is early days and we would consider partnerships with other organisations.

6. What are the major challenges of working as a provider of CSSs?

In making major change programmes work, there are all sorts of considerations and the process can be lengthy and often contentious. There are also regulatory burdens in the health service at the moment which can also present difficulties for the project. There are other issues are around capacity in the service. In some CCGs there are not very many people, to be honest, and so if you are looking for people to be engaged in helping to lead and drive change, they are busy, which can also lead to difficulties for us to facilitate changes.

7. How do you see the CS market evolving?

I think it is too early to tell. I think there will be a mix and match approach. So a lot of CCGs will want services from CSUs but they may also want particular help for particular projects from other firms, such as ourselves, which they could either purchase through the ConsultancyONE framework for consultancy services or via the lead provider arrangement if that is what is appropriate.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

We are investigating that, yes. We are talking to a number of CSUs as to whether they wish to partner. I doubt whether we would want to be the lead partner in a proposal because we are focused on the strategic change portion of commissioning support which is only one element of what CCGs need support for. So we would like to partner rather than lead. In partnering with multiple CSUs on different frameworks, an issue might be to make sure

Biography

How does your career so far help you in working with the NHS?

I have worked in the NHS prior to joining BCG for about 20 years. I am a GP by training, I have been a director of commissioning in a health authority, a chief executive of a primary care trust and a chief executive at a teaching hospital. I have also worked in the Department of Health for a couple of years, so I have done a range of jobs which allows me to understand the service. I have been at BCG for three years, and I was chief executive at University Hospitals Bristol Foundation Trust prior to this role.



What attracted you to working in this area?

I am attracted to working on complex issues which require fresh thinking; a mixture of people skills, data analysis skills, political skills around change. So, complex problems are interesting areas to work on.

What do you enjoy doing outside of work?

Spending time with my family, travelling, keeping fit with some running.

there's no conflict of interest between bidding parties.

BDO

Independent Sector Provider

Chairman: Steve Smurthwaite

1. What CSSs will you provide over the next 12 months?

Our present core offer is an innovative and flexible consulting approach which falls into three main areas: strategy, performance improvement and governance. This applies across all our markets, be it clinical commissioning groups (CCGs), commissioning support units (CSUs) or Trusts. At the moment, we are looking to replicate our offer in those three areas within CSUs and that is what we have been doing with Anglia, North West London and in Kent.

For the longer term we are exploring alternative models to the traditional client-consultant relationship and to develop partnerships and joint ventures with CSUs. For example, if a CCG has a particular requirement to improve a service or to undertake a review of its local health economy, we could go to market together with a CSU, thereby combining our strengths and expertise in our respective areas with

local knowledge.

2. How is your business structured?

BDO LLP (BDO) is the UK member of the BDO international network, the world's fifth largest accountancy organisation with representation in more than 138 countries.

The firm is the UK's sixth largest accounting and financial advisory organisation and operates from 23 offices providing nationwide coverage. BDO has over 3,500 staff and partners in the UK.

The BDO Healthcare Advisory practice is a core team of specialists supported by a broad associate network, with access to the skills and expertise of the wider firm, both locally and internationally.

Our core team includes professionals with NHS backgrounds in operational management, finance, procurement, nursing, acute medicine and surgery, and general practice.

BDO also has a global outsourcing

capability which we believe will be of great interest to CSUs and CCGs as they look to improve the efficiency and effectiveness of back-office services.

3. What is different about your organisation, and why should commissioning organisations come to you?

We bring a fresh perspective and innovative ways of working. Underpinning our culture is a set of defined values that reflect how we manage our work, our relationships and ourselves. These are honesty and integrity, mutual support, strong and personal client relationships and taking personal responsibility.

In addition to our core team we have access to a large network of alliances and associates allowing us to draw on the right level of expertise as required. Our associates include professors with international reputations, finance directors and CEOs through to health planners, health informatics professionals, clinical coding experts and beyond.

For example, we worked with Influence At Work and general practitioners to reduce missed appointments in general practice, looking at how they communicate with their patients and staff. We found evidence to show how that reduces the level of Did Not Attends – missed appointments. We believe this is very innovative work and something nobody else is doing in the market.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

The challenges are enormous. One is they are such new organisations and they are untested. They are just finding their feet, with massive responsibilities and accountabilities that they have to get to grips with in a very short period of time.

The Trust sector faces many challenges of its own but is very well established compared to CCGs and CSUs. This means there is an imbalance of experience and knowledge.

NHS commissioners have so much to

Facts and figures

Number of dedicated staff in the healthcare team: 25

Current CCG, CSU and other NHS customers: Camden CCG, Islington CCG, Southwark CCG, Islington CCG, Guildford CCG, Blackpool CCG, Hampshire, Fylde & Wyre CCG; North West London CSU, Anglia CSU, Kent & Medway CSU; West Hertfordshire NHS acute trust, North West London Hospitals NHS Acute Trust, Blackpool Hospitals Foundation Trust, Birmingham Children's Hospital NHS Foundation Trust, Taunton & Somerset NHS Trust, Yeovil District NHS Acute Trust, Cumbria Partnership NHS Foundation Trust, Cornwall Partnership NHS Foundation Trust, Somerset Partnership NHS Foundation Trust, East Midlands Ambulance Services, South Central Ambulance Services

Percentage of income from NHS contracts: 95%

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: 20%

Service coverage/types of service provided: Strategy: Integrated business planning, merger proposals, commissioning strategy, procurement; Performance: Cost improvement programmes (CIP)/quality innovation, productivity and prevention (QIPP), economic and quality performance reviews, service re-design, managing; demand and capacity, outcomes commissioning development and contract reviews Governance: Review of board governance assurance frameworks, leadership and organisational development, external audit of finance systems and processes, business advisory services for GP Practices, fraud advisory and internal audits
Main competitors: The Big Four accountancy firms, niche healthcare consultancies and McKinsey

learn and it is an environment that is highly pressured and not very stable. They face a huge agenda in terms of providing quality under huge financial pressures.

The second challenge is around the variable size in the CCGs and I think that the small ones particularly, must be feeling under-resourced to be able to grapple with the challenges that they face in addition to learning what those agendas are.

Commissioning support can add value by providing scale, expertise and stability. Where they are working with an external partner like BDO they can also bring a more commercial approach to developing strategies for transformation, performance improvement and governance. This is more likely to deliver the most efficient and effective solutions to their challenges.

5. What partnerships or planned partnerships do you have? Who does your network include?

A core part of our ethos is to form relationships that enable us to establish teams with expertise specific to our clients' challenges.

We therefore have a wide network of associates who have a range of backgrounds, including organisational development, service transformation programme management and behavioural science.

Our partnerships include Capgemini, Atos, The Cass Business School, FranklinCovey, and Influence At Work.

6. What are the major challenges of working as a provider of CSSs?

CSUs are still finding their feet because they have not been in place for very long. A lot of them have inherited a number of systems and different ways of working from PCTs.

There has been high turnover of people in CSUs so a lot of organisational memory has disappeared. In addition, they face externalisation and competitive pressure due to autonomisation.

Going forward they will need external support from providers like BDO because of the commercial and business skills we offer. Not all of them recognise this yet but some are

Biography

How does your career so far help you in working with the NHS?

My career effectively started in the NHS. My first job after qualifying as an accountant was at Addenbrooke's Hospital. Ever since, I have worked either in the NHS or for the NHS in one form or another. My last job in the NHS was a director of finance of an NHS Trust in Blackpool, after which I moved to work with Tribal in a consulting role. In all that time, 99% of my client work has been for the NHS, but covering broadly the three areas around strategy, performance improvement and governance. Having worked with every type of NHS organisation you can think of, I have a really good general overview of the whole of the NHS. So I can see how it fits together and understand the drivers behind different parts of the system.



What attracted you to working in this area?

When I set out on the early part of my career I felt it was somewhere I could make a difference. It interested me more than the private sector at that time, when I was training. At the time, the NHS was very poorly served by its finance function. So, very early in my career, I thought, 'That is where I can really make a mark quite quickly'; and so it proved, because I was a finance director at quite a young age and I feel as though I have continued to make a contribution, so I have just stayed with it.

What do you enjoy doing outside of work?

I make time for exercise, particularly cycling and walking.

starting to explore the potential for working in partnership with the private sector.

7. How do you see the CSS market evolving?

The market is in a state of flux. There are already mergers taking place and we'd expect to see more in the foreseeable future. While this makes good sense for the back office transaction processing functions it may be the case that CCGs will want a more local service for others such as contracting and service improvement teams.

There is definitely interest from commercial providers in the lead provider model being developed by NHS England. We expect a very mixed market to emerge from this. This will be based on local factors such as culture, history, geography, relationships and primarily needs. There will be some areas where commissioners are quite aggressive in changing their arrangements for support while others may be content and make only

marginal change for parts of it. This means providers like BDO will need to be flexible in our approach and not assume one size fits all.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

BDO is interested in the CSS models that are being developed. Whether we would go as prime or as sub depends on what the scope is and what we see as the relative strengths of ourselves and our potential partners as well as the other alliances that are being formed. At the moment we are keeping our options open.

BT

Independent Sector Provider

Head of analytics practice: Gavin Mander

1. What CSSs will you provide over the next 12 months?

We see analytics as being at the core of our commissioning support services (CSSs) offering. At a basic level, we want to help commissioning support units (CSUs), clinical commissioning groups (CCGs) and GP practices, get a better understanding and consolidation of their existing data assets.

There will be a number of different places and systems where their data is stored and we can help them provide a single data asset, which they own and can exploit. By pulling a single picture from data collected at different touchpoints of a patient's journey, they will be able to better understand the end-to-end pathway of their patients and make more informed commissioning decisions.

We have put a significant amount of effort into consolidating a large number of open data assets that the UK government has made publicly available over the last couple of years. For example, this includes aggregated data in the area of diabetes including quality outcomes framework (QOF) targets, A&E attendances, prescribing data or a breakdown of the demographics of a particular practice, which we pull together from a range of data sets to inform CCGs on performance within their region as well as how they're doing against their peers as it is open data. We also have an extensive understanding of secondary uses service (SUS) data and are keen to work with commissioners to help them gain greater insight from that resource.

We have a platform that allows consolidation and integration of existing customer data assets with the open data assets to provide insight into the organisation and allow collaboration across organisations. We have a cloud based patient-identifiable secure platform, which provides an alternative to local infrastructure. To help commissioners maximise the value being provided by their analysts, we can provide access to pre-aggregated open data and benchmarks as well as tools that allow self-serve and the creation of their own reports and dashboards. Moving forward, we are exploring how we can apply big data capabilities to help organisations understand how they can optimise their care pathways and the way they are delivering their services. Big data comprises of a set of tools and capabilities that allow you to manage the huge volume and variety of data that is available in the NHS at the moment. There is also potential around using our existing social media monitoring and customer engagement tools to get feedback and improve patient engagement.

2. How is your business structured?

BT consists of four customer-facing lines of business: BT Global Services, BT Retail, BT Wholesale and Openreach, which are supported by our internal service unit, BT technology, service and operations.

In terms of health, we have account managers and delivery teams that sit within the customer organisations. The likes of the practice teams such as myself have expertise

that we would deploy as required to clients if there are particular areas they want support or guidance on. From a delivery and service management perspective, we have a single organisation, which means that best practice and lessons learned are applied across all of our customer base.

3. What is different about your organisation, and why should commissioning organisations come to you?

We have a legacy of managing certain aspects of the National Programme, which proved to be successful such as N3 and Spine services. As one of the local service providers (LSP), we delivered services to 19 acutes and 62 community mental health trusts, so we do see ourselves as an organisation that partners with customers through thick and thin. We want to create long-term partnerships and be a trusted partner of these organisations, which we have demonstrated over the last few years.

Furthermore, I have had four years of experience of running the secondary uses service (SUS) programme, and we want to help CCGs and CSUs get more out of SUS data, such as providing greater insight into re-admissions to help commissioners better understand how much they could be withholding and where they should be focusing their efforts to improve readmissions rates. From our senior leadership team, we also have very recent experience of the NHS through former NHS England chief operating officer and deputy chief executive, Ian Dalton, who joined us at the start of May, while at a working level, we have a number of people who have clinical and NHS experience.

Another differentiator is that we aim to operate at scale while delivering capability locally. If we look at open data, for example, every time there is new data that comes into that data set or particular tools or insights we can drive from the data, we will make sure it is available to all our customers. Likewise, we learn lessons from any problems that we have and make sure that it does not apply again across other customers. Furthermore, we have an excellent clinical risk management capability to make sure that the systems we provide are assessed against all the clinical risks that they could encounter. We have a team who

Facts and figures

Number of dedicated staff in the healthcare team: BT operates a flexible resource pool

Current CCG, CSU and other NHS customers: BT provides services to many of the CCGs from network services through to transformational programmes

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: BT provides a range of services from audio and video conferencing services or mobile working through to telehealth and interoperability as well as analytics and commissioning support

Main competitors: undisclosed

understand all of the regulations that you need to apply for bringing new services, products or capability into the market.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

NHS commissioners are looking to continually improve outcomes and drive cost efficiencies. We believe we have a range of services that can help achieve that. When looking at operating within the new commissioning landscape, CCGs need to be able to make informed decisions as to how to best deliver their services whether this is 'in-house', from CSUs or from elsewhere. Bringing clarity around the roles and responsibilities across the different stakeholders has been one of the key challenges over the last few months. For example, is a CCG able to choose services from any of the CSUs, can they go out and procure in to the private sector rather than from a CSU? From a CSU perspective, how can they maximise the take-up of their services and potentially advertise their services to other CCGs? There is a question around what role private sector providers can play, which could be a reason for the proposed CSSs framework. If procurement frameworks are put in place, the key is to allow them to drive innovation and avoid being too prescriptive or rigid. There is also a need for simplicity as there are already a variety of frameworks out there and they all need to be complementary, with no conflict of interests and enough clarity on which frameworks to use.

5. What partnerships or planned partnerships do you have? Who does your network include?

One of the strengths from a BT perspective is that we are largely agnostic in terms of who we work with. We will bring together the right partners to deliver what is right for the customer. We are not in a position to announce specific suppliers at the moment but can provide more details over the coming months.

6. What are the major challenges of working as a provider of CSSs?

Looking at this from a procurement perspective, there is a challenge in ensuring we clearly

Biography

How does your career so far help you in working with the NHS?

I have worked on a range of health programmes over the last 10 years such as Connecting for Health in 2003, working on Choose and Book and the picture archiving and communications system (PACS). I moved to BT in 2006 where I managed the patient demographics project before running the SUS Programme for four years. Prior to BT, I worked for Deloitte Consulting.



What attracted you to working in this area?

I'm motivated by delivering tangible benefits to customers.

There are a lot of industries where you do not really see the tangible benefits and outcomes. From a healthcare perspective it impacts family, friends and everyone you work with which brings an additional level of motivation.

What do you enjoy doing outside of work?

I have a young family (a 20-month and 4-month old), which keeps my hands full juggling work commitments with spending time at home.

identify who our customers and competitors are. For example, will CSUs be customers or competitors, as this could drive competition between CSUs and the private sector.

Operating at the appropriate scale is a challenge for both us and our customers – we aim to help commissioners understand the contributory factors driving cost and quality in an end-to-end pathway. Where pathways work across a number of health boundaries including primary, secondary, community, mental health and social care, there is a risk that whole health economy benefits are not realised when procurement is pushed to a CCG level.

There will be a potential challenge around access to the right data to deliver the services on the frameworks, which would depend on controls placed by NHS England and Health and Social Care Information Centre (HSCIC).

7. How do you see the CSS market evolving?

In our view, we would like to see how we can support closer working partnerships being put in place between the NHS and the private sector. We think there is a lot we can contribute such as helping to manage and optimise information from core data sets through to enabling analysts to focus their energies on

service redesign and providing more value-add to patients. Building partnerships within the commissioning market will be key for us moving forward. As the commissioning market matures we believe collaboration and partnerships will be a key success factor.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

We would be interested in both leading and partnering having had previous experience of both in other contexts. For example, on the National Programme, we primed and managed a large number of suppliers. From our perspective, the most important factor is understanding what business outcomes they want, and we would work to bring the right BT capabilities and partners together to achieve that business outcome.

Capgemini

Independent Sector Provider

Vice president: Martin Charters

1. What CSSs will you provide over the next 12 months?

Capgemini's approach to providing commissioning support services is twofold. Firstly, we will provide services directly to clinical commissioners in specific areas such as whole system transformation, service reviews and specific emerging themes, such as outcomes/value-based commissioning.

Secondly, our aim is to work and develop partnerships with commissioning support units (CSUs) so that we go to market jointly, building on the skills and expertise that they have to develop integrated offerings. With that in mind, as well as the more traditional service offerings such as system integration, business intelligence (BI), product development and back-office business process outsourcing (BPO) services, there is obviously some work we are doing with CSUs around future form – their organisational design, their organisational development, service transformation and performance delivery.

We will help them to develop commercial offerings or identify ways we could work together to enhance their performance in a particular area which would help them bid for a particular piece of work. We're also working towards helping them to diversify their portfolio to allow them to expand their market so that they're not confined to

providing services for clinical commissioning groups (CCGs) but for other client bases such as NHS England, the social care commissioning market that local government run as well as other government departments with significant commissioning needs.

2. How is your business structured?

Capgemini is a global consulting IT and outsourcing business covering a whole range of sectors including healthcare, retail and banking. We are one of the largest suppliers of services to government in the UK.

It brings together consulting, systems integration and outsourcing capabilities. As head of our health consulting practice, I work closely with Andrew Jaminson who leads the health technology business, to focus on the market for commissioning support services.

It is our job to work out what the requirements of the CCGs and CSUs are, and make sure we can tailor our approaches and capabilities to meet their needs. We will bring together the skills and resources from across the Capgemini group, and where appropriate, work with SMEs to provide specialist skills and systems.

3. What is different about your organisation, and why should commissioning organisations come to you?

On the consultancy side, we have very

specialised services around moving organisational design into a digital space, which includes bringing in expertise from other sectors such as retail and utilities to provide an all-channel experience for customers. On the support side, we can help CSUs bring together health information exchanges and business intelligence to provide connectivity that can be commercialised and delivered to CCGs, making sure that the huge area of sharing information securely is observed.

Furthermore, we can mine the information so that it provides BI not only for commissioning decisions but also for social care. On the long-term strategy side, being a world leader in back-office BPO with 120,000 staff worldwide, we can bring our experience of models that have been known to be effective in our cross continental work in health services or use knowledge and insights into a particular area to deliver the service back through CSUs. For example, our Swedish practice is heavily involved in integration between health and social care and providing systems that can manage effective care delivery, and that is going to happen more and more in the UK.

Furthermore, we are not just presenting back bits of CapGemini, but bits of SMEs involved that have added value. A key differentiator is that we do not feel compelled to deliver sales directly from CapGemini resources. If we feel that other SMEs are in a better position to fulfil requirements, we will provide the integration that makes it work and the consultancy that faces it off, rather than go back into the bowels of our own organisation and say, 'If you painted all these things blue we could give it back to them and tell them it is new,' which some competitors may do.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

I think key challenges now are similar to what primary care trusts (PCTs) and practice-based commissioners were saying a few years ago when we worked with Mark Britnell, currently global head of health at KPMG, on something called world class commissioning. This includes the absence of the right information

Facts and figures

Number of dedicated staff in the healthcare team: undisclosed

Current CCG, CSU and other NHS customers: A range of CCGs, CSUs and other NHS customers on a variety of projects including CRM systems, care pathway development

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: CRM systems, care pathway development, clinical decision support, IM&T strategy, organisational development, target operating model, performance improvement and transformation, business intelligence and health information exchanges, whole system transformation, programme management, information and value-based commissioning

Main competitors: We typically come up against the accounting firms, McKinsey, PA and a range of niche providers. On the more integrated, BPO, systems and technology opportunities, competitors are more likely to include Accenture, Capita, Serco and IBM

or the inability to use the information that is available to us. Another challenge is delivering major transformation because of demographics and improving outcomes while keeping the existing show on the road. The third element is demonstrating that CCGs are using new tools, techniques and innovation, such as value-based commissioning from across the globe. Part of our job is to bring that innovation into those CCGs and balance what is available with what patients want.

5. What partnerships or planned partnerships do you have? Who does your network include?

On the advisory side, we work with niche experts such as Beacon on mental health and an organisation called Outcomes Based Healthcare, which is a growing area of expertise. We also work with some of the mid-tier accounting firms, such as BDO to provide financial expertise, and specialist IT/software providers.

On the IT and services side, for business intelligence, we are working with Ascribe, and on the information exchange side we are working with an American company called Net.Orange, who are working closely with the Healthcare Finance Management Association. That is not just to cover information exchanges, but extends into care pathway development as well. The other organisation we use for care pathway development is called InferMed, a small company that came out of cancer research. On the long-term strategic side, we have a number of ongoing discussions, as you would expect, with a range of potential partners.

6. What are the major challenges of working as a provider of CSSs?

There are a bunch of organisations (CCGs, CSUs and other players) that are just evolving. So they are just trying to understand what they should be doing, and we are having conversations with them that are one of 500 conversations that they are having. As a supplier, a challenge for us is to work out what they need and try to explain our propositions and solutions in a way that they understand. The second one is that the length of contracts

Biography

How does your career so far help you in working with the NHS?

I qualified as a chartered accountant working in the private sector, prior to joining Grimsby Hospital to support their development towards Trust status. I have spent most of the last 22 years working in and for the NHS as a consultant. Initially focused on finance and capital development, I have more recently worked on board development, service transformation, clinical and commissioning strategy and whole system change. I have been with Capgemini for the last five years



What attracted you to working in this area?

Most of my family work in the NHS, although they are on the clinical side. It was a natural place to go and work. It offers a huge variety of challenges and opportunities to explore and develop.

What do you enjoy doing outside of work?

My passions are trekking, gardening and I am a bell ringer as well.

they can bind to and the contracting mechanisms that they currently have are both limited and open to interpretation due to their being newly formed organisations who are still deciding whether they will build into their own capabilities, turn to CSUs or form their own cooperative arrangements outside the CSUs for commissioning support. A third one is that due to a step-back model where CSUs are now required to sell their services, providing them with financial constraints, neither big organisations like CapGemini, IBM or McKinsey nor small SMEs can expect to go to a CSU and say, 'We are expecting a capital project for £15 million to do this,' because they will just laugh. So, we have to train our business to understand the way in which people will buy things from us is both to pay for it as they use it, and also increasingly associate it with the benefit that they derive from it.

7. How do you see the CSS market evolving?

We have seen one or two CSUs fall by the wayside and it is highly likely that others will amalgamate into other partnerships. In order to become a stable organisation, it is highly likely they need to diversify to cater for other client bases such as NHS

England, the large social care commissioning market that local government run, and other government departments that have significant commissioning capability such as prison service national offender management service (NOMS). The other issue, which is a market issue, is related to the intention of the reforms to become much clearer around an NHS England commissioning and an independent regulated provider sector. Actually, I think big suppliers are going to have to start thinking about which camp they want to play in because the inevitable consequence is if you are commissioning or working with commissioners in a large way, you end up with all sorts of potential conflicts if you are also delivering services to the provider side. I think sorting out those conflicts is going to be a big issue for providers into the market.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

Yes, absolutely. We would be interested in leading for the framework and partnering with others including CSUs.

Capita

Independent Sector Provider

Market lead director of commissioning: Will Perks

1. What CSSs will you provide over the next 12 months?

We provide services across business support, commissioning cycle and clinical support services. Capita has a strong track record in providing business support at scale across a range of markets, particularly HR, finance and IT services. In health we've done lots of work around supporting the commissioning cycle including commissioning strategies (including clinical strategies and quality, innovation, productivity and prevention (QIPP)) planning and executing large scale transformational change and redesign programmes, market/provider management and contract monitoring. We see real opportunities to deliver step changes in performance and outcomes through these services by taking a system wide view, including the cross over into social care, and understanding/redefining the relationship between commissioners and providers. In terms of clinical support services, at the moment we are most strongly placed in continuing care and have done a lot of work around benchmarking and improving assessment processes and reshaping market supply/ re-procurement.

Much of the support we provide tends to cross clinical commissioning groups (CCGs) because of the scale and nature of the work, around a particular provider issue, or a major

QIPP initiative, for instance. Looking forward, we would expect the pace and scale of support we're providing to increase as CCGs tackle challenging issues to improve the quality and impact of commissioning spend.

2. How is your business structured?

Capita is a UK leading provider of business process outsourcing and integrated professional support service solutions.

Our structure is quite simple really. Capita's engagement with NHS commissioners and commissioning support units (CSUs) is led by our health advisory team, which does consultancy across commissioners, providers and social care and leads the transformation work that we do with CCGs. That team sits in health and wellbeing, the Capita division that provides health and care related services to NHS customers and other clients. CHKS and Clinical Solutions, companies bought by Capita, sit in the same division. We also draw upon the wider experience and capabilities of Capita Group; for example, HR recruitment and payroll services, financial software and services, large scale IT outsourcing etc. This gives us maximum flexibility to combine specialist NHS commissioning expertise and advice with large scale service delivery experience across health, local government and the private sector.

3. What is different about your organisation, and why should commissioning organisations come to you?

Capita is the transformation partner of choice for many of the UK's most successful public and private sector organisations. For example, in West Sussex, who are one of the largest county councils, we are delivering back office support like HR, payroll, procurement and IT services at scale. We also have other local government and private sector partnerships in place. In Birmingham, we have a joint venture with the city council and are looking to deliver something like a billion pounds of cashable savings over a 10 year period through a transformation programme that combines strategic advice and delivery support across nine service areas, both frontline and support services.

And while we are very good at doing business support at scale such as running a HR recruitment service, IT services, payroll etc, we also have strong differentiators specifically around commissioning. We probably have more track record than any other firm of delivering commissioning support services (CSSs). Under the framework for procuring external support for commissioners (FESC), for example, we supported NHS commissioners responsible for the health of one sixth of the population.

With the advantage of this track record, we are very strong in developing models that help with thinking about commissioning intentions and the implications, and we can also help with the change management required to act on the opportunities around that.

We see ourselves as being true partners in transformation, which comes back to the values of Capita. We have worked very well in partnership with NHS commissioners by ensuring that our goals are aligned to those of our customers. Part of that partnership may mean tying our payments and outcomes into achieving the desired changes in pathways and reshaping of outcomes for patients.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

Delivering better outcomes in an increasingly

Facts and figures

Number of dedicated staff in the healthcare team: 2,000

Current CCG, CSU and other customers: 40% CCGs including clients in London

Midlands, East of England, South Coast, Yorkshire, North West & the Home counties

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: Commissioning services; advisory services: whole systems, commissioners and providers; clinical decision support; clinical coding; BI/benchmarking; patient surveys; education and training; IT services; HR shared services; executive and clinical staff: interim/ permanent; occupational health services; finance applications services; clinical assessments (eg. DWP/insurance sector); forensic medical services; medical travel assistance.

Main competitors: Around consultancy work we compete and also work with, 'big four' firms and some niche players. For large service contracts it might be ATOS, Serco, United Health or IBM

challenging financial environment, controlling demand for acute services and challenging providers without destabilising the system are challenges most commissioners are facing.

There is the on-going quality agenda, which is to do with thinking about the outcomes that really matter for patients and how providers can be better aligned across the care pathway to make sure those outcomes are delivered in spite of financial pressures, because at the moment there are a lot of disincentives in the system that prevent providers working together in a meaningful way. While part of it is about joining up services better, some of the work we've been doing around Right Care and shared decision making, which is about how you ensure that patients have a meaningful and informed choice at appropriate points in their treatment, is also relevant.

Then there is the challenge of system sustainability, which centres around issues of finance, governance risks, clinical risks, safety issues, which many trusts are now ringing the alarm bells around.

For the last few years, the NHS approach to QIPP has been largely around chipping away at services such as reducing length of stay or follow-up attendances, but there are limits to what this can achieve, and we believe delivering change that is much more transformational in nature and wide-reaching across providers will be required, which is where we feel our services are particularly relevant.

5. What partnerships or planned partnerships do you have? Who does your network include?

We want to partner with people who are passionate about making a difference and have complementary capabilities to our own. This includes NHS organisations, other independent sector players and with third sector organisations as well, so our discussions at the moment are fairly broad-reaching.

6. What are the major challenges of working as a provider of CSSs?

There is something about the maturity of

Biography

How does your career so far help you in working with the NHS?

I have been working exclusively with NHS clients for the last eight years including as the provider of a range of commissioning support including invoice validation, risk stratification, health coaching, and evidence based pathway re-design. Prior to this I had been involved in running a number of organisations. I guess collectively this gives me a range of perspectives from which to help the NHS.



What attracted you to working in this area?

It may sound hackneyed but genuinely to make a difference. Through the provision of commissioning support services so much can be improved and the precious resources the NHS has can be maximised. It is also work that I love.

What do you enjoy doing outside of work?

Having a young family fills most of the spare time I have.

the market which I think is a challenge. CCGs sometimes need help to understand what good looks like and how they should expect CSSs to develop going forward. Given the amount on CCGs' plates at the moment, there is a danger that everyone is focused on transactional support, with less time spent on the strategic and transformational services that will deliver greatest impact.

The other challenge is driving the benefits of scale and working together while keeping an appropriate level of local responsiveness and flexibility. We see the same tension playing out in other sectors and there is a real opportunity to learn from how, say local authorities, have tackled this.

7. How do you see the CSS market evolving?

I can certainly see it coalescing into between five and ten strategic partnerships over the next 24 months or so, which will have enough reach to cover most of the country and be sufficiently competitive and sustainable. I suspect that would be expedited by a process like the framework, because that begins to prompt certain strategic alliances which then become much more formalised on the back of contracts and work that is won.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

At the moment we are pretty open minded. We could lead, likewise partnering is in our DNA and we're open to working closely with NHS CSUs. The key for us is how we can add most value for CCGs, locally and at scale.

Independent Sector Provider

Health industry director for the vertical: Rebecca Trewinnard

1. What CSSs will you provide over the next 12 months?

We are looking at a few options including providing cloud solutions, business intelligence, outsourcing, IT strategy and working as a partner to deliver business transformation.

With regards to cloud solutions, it is quite clear that the CSUs may want to do short-term contracts, and there are a number of solutions that we are putting towards G-Cloud in the next few months. In the area of business intelligence, we are looking at the integration of different datasets into one space, enabling the sharing of data within health, local government and everything supporting the continuum of care, making sure information adheres to the correct standards and security measures, and furthermore, that data is relevant by mapping it against the public health agenda and healthcare agenda.

Moving forward, as CSUs become more stable we can look at more advanced types of analytic services using unstructured data and a whole raft of information beyond general day-to-day things. In the long-term, we'd also use clinical research and ongoing commissioning outcomes to inform business intelligence and see how we can move towards preventative measures.

We also do very large scale IT outsourcing and have just been awarded a major long-term contract with NHS Solent and are competing vigorously on other opportunities. Our work ranges from providing consultancy to delivering projects on site.

2. How is your business structured?

There is a health vertical within the UK system processing unit (SPU) which is the business unit (BU). The vice president of healthcare, runs the BU which includes a single sales director and two delivery directors, responsible for client relationships. I work across the whole of the vertical and link into other areas such as consulting, which includes business analytics and electronic document management, business change, and areas that look after the hardware, hosting and cloud. Teams are assembled depending on the specific requirements of each project, and while we may help to bring delivery people into a project, somebody within the vertical is usually part of the account management so we never actually lose the connection with the customer.

3. What is different about your organisation, and why should commissioning organisations come to you?

CGI, formerly Logica, have had a strong presence in healthcare for many years, with the Ministry of Defence, University College London Hospitals (UCLH), the work we have done at Spine (part of Connecting for Health) and more recent wins at other trusts. The merger with CGI has increased the focus on healthcare which is one of five main business priorities for CGI, globally. CGI, which is a very successful systems integrator from Canada, allows us to be a new business in a way, and both companies have had a history of successful long-term partnerships with some

very large strategic organisations within the healthcare economy in the UK and across the world. Our experience of delivering solutions worldwide is something our competitors may not have. For example, most healthcare work in Finland is delivered by CGI and we also have a great presence in Denmark and Sweden which are similar markets to ours. This experience means that we're bringing what's been trialled and tested rather than just plugging a solution and asking "Will it work?"

An example of a long-term partnership we've had is with UCLH who we've worked with for ten years, bringing it from absolute pandemonium to a proper business partnership where we have delivered solutions and even run procurements on their behalf. We are also different to the other system integrators in the UK market because we do not just provide other people's products, but also have some in-house developed products that have been developed in partnership with UK hospitals here so that they are fit for purpose for our UK market.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

Some of the data that commissioners need is still very much locked down in paper, and it will be a while before the data can be mined. This is especially as it is a very difficult model for commissioning services given that just in London, there is such a big disparity between affluent and deprived areas, which furthermore, can change drastically within a short span of time, such as King's Cross for example.

You also have challenges like NHS Direct pulling out of 111 and more people presenting to accident and emergency (A&E) because it is a 24/7 environment. Whereas some of us used to be prepared to wait, nobody is now willing; therefore, how do you plan your activity? Commissioning is very much an art and there are still not that many commission-trained experts out there. On top of that, there is the big challenge of delivering better outcomes for the same amount of money, which basically amounts to a cut as there is a thing called inflation. With these financial pressures,

Facts and figures

Number of dedicated staff in the healthcare team: 50

Current CCG, CSU and other NHS customers: We work through some of our partner trusts with about 10 CCGs in London; seven CSU and other NHS customers

Percentage of income from NHS contracts: 100%

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: 50%

Service coverage/types of service provided: Digital hospital, integrated health economy, long-term managed services

Main competitors: CSC, BT, Capita, IBM, Orion, HP

providers are going to go for best tariff which may mean a much more polarised NHS and commissioning for economies of scale, which means controversially, there may end up being too many hospitals, but who wants to sacrifice their district general hospital? It is the commissioners who are going to have to make those very tough decisions.

Commissioning support services can provide key infrastructure at the backend such as IT outsourcing so commissioners can concentrate on delivering clinical services as well as support transformation by providing the right information and integration of data to streamline services and improve patient flow. It is about analysing the data and seeing peaks of where money has been saved in the context of outcomes for the patient. For example, if you're a 25-year-old female living in an affluent area with a good diet and exercise, then you might have better outcomes on this drug than the single mother with three kids on a very low income and poor diet.

5. What partnerships or planned partnerships do you have? Who does your network include?

We have a number of key partnerships with organisations like Oracle, Microsoft, and IBM, all of which makes us strong and enables us to provide the types of services that we believe commissioning support units would want.

6. What are the major challenges of working as a provider of CSSs?

Commissioning support units (CSUs) face the challenge of being on really tight budgets. Some hospitals are still aiming to be foundation trusts but they are not all going to make it. They also face really difficult IT environments, with most of them trying to bring together a lot of disparate systems inherited from primary care trusts (PCTs). They have got a lot of core infrastructure, wrong data, not validated data and data all over the place in silos. If they are communicating with the private sector they have then got the issue of information governance as the private sector has not got a direct right to be on N3, which is the network for the NHS.

Biography

How does your career so far help you in working with the NHS?

I have worked at CGI for six years and before that I worked in the NHS for 20 years in primary, mental, acute and social care. I worked on things like the National Screening Programme; the Exeter system which pays GPs, built a few hospitals and clinics via private finance initiatives (PFI) and Lift and then I moved into the supply side. Directly before this role, I worked at one of the largest PTCs in the country as deputy chief executive.

7. How do you see the CSS market evolving?

Even though there is a learning curve, I think that there is no doubt that independent sector providers will be looking to provide services in the CSU space. What you might find is that the easiest way into the market for some of them might be to just wait for the weaker CSUs to fail and then take them over. After all, the government's view of the CSUs is that they will become commercial organisations within two years, and will stand on their own right anyway. Once that happens, I think you will see the strongest CSU buying out the stronger CSU and a pretty frenzied free-for-all among some of the bigger independent outsourcing companies such as Serco, Capita and one or two of the big American ones like HCO taking over the smaller CSUs. It could be a really good marriage as the private sector will have a bit more money to throw at it, people with more commercial experience as well as better IT infrastructure while CSUs have the real expertise in the frontline commissioning and buying of services.

8. CCGs have shown an interest in procuring CSS via prime or alliance provider models – would you be interested in this?

I would say that it is something we are monitoring but we have not made a decision yet.

COBIC

Independent Sector Provider

Executive director: Andrew Smith

1. What CSSs will you provide over the next 12 months?

The commissioning advice and support that we are providing now is moving clinical commissioning groups (CCGs) away from payment by results and one-year-activity-based contracts on to 5-7-year contracts for populations. This means identifying a cohort of patients, for example, over-65 year olds in Oxfordshire, and working with the commissioner to incentivise all elements of the providers' market for that cohort to work together more efficiently as a collective. This includes primary care, secondary care, community care and the local authority. And rather than just looking at numbers and activity, we will aim to provide the outcomes patients want using a defined budget. For example, it is not good enough that a patient goes to hospital and receives the treatment and then gets sent home again as that is a process, not an outcome. An outcome would be the patient wants to be treated in, or closer to their home or to get back to work. But, at the moment, the incentives are all wrong to enable that to happen. We engage with patients to find out what outcomes they want, work with providers to help them understand that and then work with the CCGs to try and get the right incentives in place to enable providers to work towards delivering those outcomes.

2. How is your business structured?

COBIC (capitated and outcome-based

incentivised contracts) offers daily, hands-on help to commissioners, GPs, doctors, nurses, social workers and anyone concerned with delivering more efficiently, better, fairer outcomes for people.

We are a limited company and we are structured in a very flat hierarchy. We are basically a group of experts in our respective fields; we have got clinicians, procurement experts, commercial experts, finance experts and patient engagement experts working with us. Nearly all of us have worked in a policy position, have either influenced or written policy and know how to continue to influence policy to make sure that anything we do is done in that context. Importantly, we have all worked on the front line, in providers, on clinical wards and in 'the field' as well, so while we know policy, we are expert in implementing it as well.

3. What is different about your organisation, and why should commissioning organisations come to you?

We are very keen that we leave behind a legacy of learning with the CCGs or the commissioning support units (CSUs) that we work with. We enjoy educating CSUs and CCGs in our methods and our approach both in terms of policy and technique so that when they come to do this the next time for a different service they, hopefully, have a far better understanding of what is required and

how to do it, and that we are brought in to help steer the ship rather than to build the ship and drive it through. So, we are very happy to organisationally develop the CCGs as we need brave commissioners for their new and innovative roles.

Equally, we want to bring about social as well as technical transformation by facilitating dialogue. Take for example, the first area to develop a COBIC contract, Milton Keynes, where we worked with partners to develop a new substance misuse contract. For years everyone knew substance misuse services could be different – more user-friendly, more local, less hospital-based and better integrated with services such as probation. We offered a contract that combined capitation and rewards for improved outcomes. The service was transformed in weeks, providing measurably better quality and experiences than before. As commissioners we saved 15-20% in year one.

Every CCG that works with us gets membership into the COBIC club which has been endorsed by Bob Ricketts of NHS England as being the group to join if you want to be at the forefront of commissioning for outcomes. He has said he will help COBIC and any members of the club to take on issues with Monitor or NHS England or the Department of Health, for example, on policy questions that they need addressing.

Another thing that sets us apart is our strength in policy and its implementation. Nearly all of us has worked in policy, allowing us to guide CCGs to push the boundaries of policy where necessary but not let policy restrain us if it is not in the patient's best interests. So, while we are absolutely aware of what the mood music is in the patient's world, we are also very, very aware of what is in the minds of ministers and policy makers, allowing us to help navigate the better solution for patients. We are quite well-connected and not afraid to push the boundaries; that is why we are a revolution in healthcare.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

I think the biggest challenge that

Facts and figures

Number of dedicated staff in the healthcare team: 15

Current CCG, CSU and other NHS customers: Bexley CCG, Croydon CCG, Herefordshire CCG, Sheffield CCG, Oxfordshire CCG, Northumberland CCG, Cambridge and Peterborough CCG; South London CSU

Percentage of income from NHS contracts: 90%

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: 100%

Service coverage/types of service provided: Predominately development of outcomes that meet the needs of patients and then to design an incentive structure for the market to deliver that service; development of a contract and a procurement process to achieve the best mix of value for money and quality of service.

Main competitors: undisclosed

commissioners face is that they are so busy dealing with the present that they don't have time to plan for the future. They are too busy having to deal with the here and now to take a step back and look at what needs to be done on a bigger scale. If they were to think longer term and bigger, such as for populations of five to seven years, the system itself would save a tremendous amount of money; providers would be incentivised to work differently and then commissioners would not have to worry so much about that service for the next few years.

At the moment, they are focusing too much of their attention on the next 12 months and playing at the margins of the service rather than focusing more on the fundamentals – this gives providers the advantage. The reason we can help with that is because we will do all that for them – the five to seven year vision – if they were to bring us in for a twelve-month programme, for example. We would deliver them savings and improved outcomes over the next five to seven years – but in a way that met the needs of the patient. So it is about thinking bigger and about being braver. We can also help commissioners represent patients better, providing them with the moral authority to take the game back to the providers and say, 'Come on guys, you have got to sort your ideas out now. The patients want better and we are here to make that happen.'

5. What partnerships or planned partnerships do you have? Who does your network include?

Some big four consultancies, a couple of legal firms, CSUs and groups of leading experts in their respective fields. We do like to work with other people – learn from them and they learn from us.

6. What are the major challenges of working as a provider of CSSs?

The biggest would be getting onto frameworks or being able to respond to tenders without having to go through a big Official Journal of the European Union (OJEU) process. It is the time and effort in responding to tenders or even being on the right framework to respond to a tender. But then again, we know that

Biography

How does your career so far help you in working with the NHS?

Well, I have always worked in and around the NHS. I started my career on the NHS financial management training scheme before going to the Department of Health (DH) on secondment to work on the independent sector programme and working at the forefront of the competition agenda. I've been in my current role since 1 April 2013 and before that I delivered the any qualified provider programme at the DH. I've got a good balance of policy and implementation experience.



What attracted you to working in this area?

I have been really interested in improving healthcare services through competition. I have also done loads of policy work at the DH and I really just wanted to get much more involved again in direct delivery of services. I really do see an opportunity now for GPs to make a difference and give patients what they really want and incentivise providers to do it. I genuinely think the infrastructure is just right now to do it, and if we do not do it now we will regress to the way that the NHS has done things for the last 60 years.

What do you enjoy doing outside of work?

Running and running around to drop kids off at all their activities, but most of all spending time with the children – ideally over a pizza.

value for money is critically important, so we understand why processes are as they are. The second challenge is probably the cultural shift required in the commissioners' mind-set, so turning from the guardian of the money passed through to providers into the actual representative of the patients challenging providers to deliver better services.

7. How do you see the CSS market evolving?

I think it will expand over the next 12 months and then contract as some organisations swallow up the smaller ones and some of the smaller ones fall by the wayside. But I think innovative providers like us will find that it is quite a good market to be in in the next 12 to 24 months. Obviously the number of commissioners will change or not depending on what happens to the CCGs, I think the model that we are delivering will become more in vogue as we get further down the line over the next 12 months and CCGs realise what they can achieve with their increased autonomy.

I know we will be busier and busier – it's great! I also think we will see more providers of healthcare wanting to use our services to help them get ready for responding to these changes in commissioning behaviours. It is the future of the NHS. We call it a revolution in healthcare. We have spoken to Number 10 about this, as well, and they want to move away from activity and to outcomes – so we have the confidence that we are in the right market.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

We would be interested in leading that framework in the first round. We see ourselves as leaders in this kind of area. We'd prefer to lead but would partner too – we are in the business of forming alliances as we speak.

Deloitte

Independent Sector Provider

Partner: Sara Siegel

1. What CSSs will you provide over the next 12 months?

Based on our current service portfolio and the demand we are seeing in the market, we anticipate providing a broad range of services. Currently we are involved in supporting strategy development, strategic planning, data analytics, cost reduction, procurement and leadership development. At present, leadership/team development with a focus on building commercial capability and preparation for externalisation is a clear priority for many commissioning support units (CSUs). We are delivering a development programme for CSUs on behalf of the NHS Leadership Academy and we also have a remit in relation to CSUs as part of our internal audit relationship with NHS England.

Going forward, we see analytics as a core service we will provide to support excellent commissioning. In our view, analytics is all about driving insight from data to inform commissioning which is focused on improving outcomes for the patient and value for the commissioner.

We also anticipate supporting complex procurements where particular skills and experience is required. For example, we are heavily involved in supporting a number of clinical commissioning groups (CCGs) in relation to their NHS 111 services. Given the considerable financial pressures facing CCGs, we anticipate that our restructuring and turnaround services will continue to be in demand and we hope to support strategic reconfiguration planning where it takes place in the next 12 months.

2. How is your business structured?

Deloitte has a typical matrix organisation structure with the primary dimensions being industry focus (public sector, private sector and financial services) and service lines (consulting, corporate finance, audit and tax). Each service line has a series of competencies -- in consulting they include strategy, technology, operations and people and programmes and in corporate finance they include a mergers and acquisitions team and restructuring).

We work on an account basis and health and life sciences is one of our priority strategic accounts for the firm. Our priority is to bring the right combination of technical and sector expertise to our clients and our teams tend to be multi-disciplinary partner led teams drawn from across the business. In providing commissioning support, we draw upon expertise from right across the firm and given we have over 12,000 people in the UK, we are able to provide our clients with every dimension of commissioning support they require.

3. What is different about your organisation, and why should commissioning organisations come to you?

Our analytics offering is a big differentiator and we are able to drive deep insight from the data we hold. We are committed to ensuring that the analysis we provide is accompanied by practical recommendations for improvement – implementation is key and we always seek to keep a strong line of sight to outcomes for patients in all analysis that we undertake. We have a large firm wide programme of excellence in analytics which

gives us the ability to apply new techniques learned in other industries to the health system where appropriate. For example we have an expert who does stock management through analytical tools for retail companies like New Look, which can then be applied to process, operational flow and stock management in hospitals. Specifically for the NHS, we are providing the national quality dashboard, which all CSUs and CCGs are allowed to have access to and can reach out to us about.

Our leadership development capability is also particularly strong and our leadership development programmes, which address the culture and behaviour change required to deal with the real world 'wicked issues' facing NHS leaders today, receive highly positive participant feedback. Commissioning of continuing healthcare is an area where our credentials are recognised in the market. Pathway mapping and reconfiguration is a priority for us and we were particularly pleased to be involved in supporting the reconfiguration of stroke services across the Midlands and East Region last year. We are particularly proud of the work of our Centre for Healthcare Solutions, which is a small dedicated research team that undertakes primary and secondary research on pertinent healthcare topics. Recent reports on that state of primary care and telehealth have been well received.

4. What challenges do you feel NHS commissioners face? How do you believe commissioning support can add value for them?

Commissioners have a huge task; they are being asked to do the role of organisations that had a very strong, installed base, when they have only been recently set up and are doing it in a time of flat funding and steadily increasing demand where there is still some lack of clarity around roles and governance. Commissioning support services (CSSs) in all guises can help, but another of their challenges is understanding how and where they can seek help. At present, it can be difficult for a CCG to navigate CSSs. The role of CSSs is to oil the wheels of the business to free up CCGs to focus on their core remit.

Facts and figures

Number of dedicated staff in the healthcare team: undisclosed

Current CCG, CSU and other NHS customers: undisclosed

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: See question one of profile

Main competitors: undisclosed

5. What partnerships or planned partnerships do you have? Who does your network include?

We have a wide range of formal and informal alliances and regularly partner with other organisations to ensure we deliver the right solution for our clients. Some of the partnerships we are particularly proud of are those with our social enterprise partners. Deloitte runs a programme called the social innovation pioneers which each year selects a number of socially minded ventures to support at no charge. Each year we get exciting and innovative healthcare partners through this programme.

6. What are the major challenges of working as a provider of CSSs?

We had a very strong and solid base of primary care trust (PCT) clients a few years ago and now that the grounds have shifted, a priority for us is building relationships across the new structures in the system. We are anxious to make sure we are delivering services that add the most value and to support the system in anticipating future commissioning challenges. We appreciate that in a resource constrained environment, buyers need maximum value from their advisors and professional services support. We are keen to explore new commercial models which demonstrate the value we add and show our commitment to improved outcomes.

7. How do you see the CSS market evolving?

Definitely consolidation of the CSU market; we have already gone down from the mid-twenties and they are hugely variant in terms of size. I think that we will also see, hopefully, a lot more change in terms of service scope; CSUs started off with a geographic focus which does not really play to core competency or actual skill and strength. So as the market is allowed to evolve more naturally they will slim down the services that they are not efficient in or good at providing; they will focus on the ones where they are proving successful and provide a smaller range of services to a larger number of clients, so there is real specialisation and comparative advantage.

Biography

How does your career so far help you in working with the NHS?

I have been working with the NHS, the Department of Health and now NHS England and the other central government bodies for the last ten years. We have been involved as a practice and as a firm in the commissioning space for that entire time. So we have seen the various waves of commissioning over the years and seen the skills grow and develop in the NHS as well as in the private sector over that time period.



What attracted you to working in this area?

For me it is a personal story. I am American, and when I first moved to the UK, I said to the person who organised the projects, 'Just put me on a big project because I want to meet people in the office because I am new to England.' He put me on a healthcare project with the DH, and it was an amazing piece of work; it was strategic, it was analytical, it involved negotiation strategy and, on the bottom line, it had a huge benefit to patients. I was hooked. I came from a healthcare economy which was hugely fragmented, expensive and manipulated by special interests, moving to one where the government played an incredibly value-added role and really brought value to patients. I thought it was a fantastic setup and system, and I wanted to do more.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

The kind of things that we look at in terms of whether we want to prime or partner in any particular consortium is where is the balance of risk, and who is the right person to be the single point of accountability. We are open to conversations about this.

Ernst and Young

Independent Sector Provider

Executive director at Ernst and Young: Derek Felton

1. What CSSs will you provide over the next 12 months?

The core of our services is around delivery of change and this includes commissioner-led service improvement, pathway redesign and system reform. Our clients use us to help them deliver better services at lower cost and to accelerate the pace of change. We not only take responsibility for large programmes of complex change management, we also support customers with smaller packages of support in the component areas of cost reduction, financial improvement, quality improvement and organisational design and development.

Where our customers ask us to provide additional support in business support services such as HR, communications and back-office financial processes, we would then look to partner with other organisations who have specialist capabilities in those areas.

We have a number of highly successful relationships with commissioning support units (CSUs) that demonstrate different partnership models. We provide high impact leadership coaching and development at one end of the spectrum and at the other we have provided services as part of a CSU team delivering new referral management and out-of-hospital change programmes for clinical commissioning groups (CCGs).

Our services are aimed to deliver fast, high impact changes that are sustainable and which encourage improvement of our clients through skills transfer and knowledge

improvement, rather than to make the NHS dependent on us in the long-term. In this vein, as clients acquire new skills, they can expect us to provide even more advanced techniques and wider insight which in turn enables them to achieve even higher levels of performance.

2. How is your business structured?

We have a very flexible matrix structure at the core of our business, which gives us the ability to treat each customer uniquely. That means that when we launch a new change programme, we will typically identify an engagement manager that will integrate the range of different skills and disciplines from across our global firm that is suitable for that particular customer. As we then work with that customer, their needs will change; that manager will use their delegated authority to flex the amount of input, skill and depth of support required to keep that customer satisfied and offer even more improvement.

3. What is different about your organisation, and why should commissioning organisations come to you?

What makes us different and what is very important in the market is the pace of change that we can execute change. Change management is at the heart of great commissioning whether we are talking about rebalancing an entire health system or whether we are talking about changing the health status and health risks of an individual person.

As well as our clients being able to expect the delivery of benefits within a certain timeframe, we are also characterised by reliability, consistency and quality of output. So if we're talking about quality innovation productivity and prevention (QIPP) for instance, we keep our eyes on the prize – delivering better care at lower cost. We believe clinical commissioners need to drive a sustainable set of improvement programmes that improve care and take excess cost out of the system – they don't expect us to follow formulaic approaches which 'ticks boxes' but fails to actually make the changes required.

We take pride in long-term partnerships that are based on reputation, trust and respect. We know what we are good at and we play to our strengths.

When we partner with other organisations to form comprehensive solutions, we ensure that we this is a way that enables our customers to access subject matter expertise wherever it lies – we would not be a bottleneck that acts as a controlling gatekeeper to our network of specialist businesses. We would also provide the flexibility to shape and evolve that supply web so that it remains relevant and up to date with those customer needs.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

I would summarise it to say that the NHS is facing massive financial challenges at the same time as needing to increase the quality of care provided. To address these issues, CCGs face the challenge of designing the right mix of support that is going to be most suited to the task. Our advice to CCGs would be to ensure that they ensure all their partners are playing to their strengths. Some services may be more effectively employed by the CCGs themselves, some carried out by a local or distant CSU and others require high-value commitment to change delivery on a risk-reward basis. In the case of the latter, organisations like ours can add value because we are prepared to put our track record on the line and actually deliver that change in a predictable period of time.

The new arrangements for commissioning support in the NHS will, in our view,

Facts and figures

Number of dedicated staff in the healthcare team: 120 (UK)

Current CCG, CSU and other NHS customers: We work in most health economies across the NHS with CCGs, providers, regulators and policy makers. We have been instrumental in the developmental journey of all CSUs

Percentage of income from NHS contracts: 98%

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: our health business has grown by 6% over the last 12 months in the UK

Service coverage/types of service provided: performance improvement, cost reduction, change management, financial turnaround, system reform, pathway redesign

Main competitors: undisclosed

professionalise commissioning techniques and enable the NHS deliver better services at lower cost.

5. What partnerships or planned partnerships do you have? Who does your network include?

We are a large global business that succeeds because we put the right people in the right place at the right time and we achieve outcomes for customers that exceed their expectations. We don't have a rigid or exclusive approach to partnering that presents a 'take it or leave it' proposition to CCGs because we commit to treat our customers uniquely and with respect and we would not wish to restrict choice in the market. We do have trusted relationships with specialist niche partners who complement the way we work and advance commissioning delivery and we are continually searching for new ideas, new thinking and exciting tools.

6. What are the major challenges of working as a provider of CSSs?

Change is needed across the NHS at an unprecedented level, and the challenge that we see ourselves addressing is that ability to help the NHS accelerate the pace of change and to achieve results of change in a reliable and sustainable way. Our customers don't just want advice, they want partners who can take responsibility for the achievement of outcomes and results.

As a provider of CSSs, we want to work with customers that have the ambition to make a difference to health systems and to be prepared to think differently about how to achieve success.

We believe that many of the historic approaches and models of commissioning are becoming irrelevant and clinical commissioners need more effective and more efficient change levers beyond an outdated commissioning cycle. I have yet to see another health system in the globe that believes it can afford an annual contracting cycle with major healthcare providers.

New providers of CSSs will be increasingly judged not on their ability to run a set of transactional business support services but

Biography

How does your career so far help you in working with the NHS?

I have had a career in the NHS as well as a career in the private sector. My background is in informatics and intelligence, and I spent all of my time in commissioning both in the private sector and in the NHS. I have also created a private sector health commissioning services business prior to joining Ernst and Young (EY). that was a series of long-term commissioning transformation programmes across the NHS for different primary care trusts. I now lead EY's commissioning practice, and that includes a wide a range of consultancy engagements and longer-term support programmes for CCGs and CSUs.



What attracted you to working in this area?

I have a strong connection with the NHS and believe that commissioning has a major role to play in improving the health of individual people and the strength of health systems. I believe that when commissioning is done well, the rewards and outcomes are huge. With the massive set of challenges facing the NHS commissioning can be considered an investment decision that the NHS is making in individuals and we want to do our part in making sure the decisions bring about change and better health outcomes.

What do you enjoy doing outside of work

I enjoy cooking, travelling and spending time with my family.

on their ability to deploy new commissioning techniques that focus much more on patient engagement, clinical productivity improvement and aligning incentives for increasing performance.

7. How do you see the CSS market evolving?

I think the commissioning support services (CSSs) market is extremely interesting. It is mature but evolving fast and many services that were previously popular and in-demand will be less relevant in the future as the concept of clinical commissioning becomes better understood.

At the moment, CSSs could be better described as functions that were previously found within a primary care trust (PCT), and therefore there are many reasons why these services will look increasingly dated and irrelevant to the challenges and opportunities of today.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

We already provide commissioning support to CCGs in an alliance model and we form fit for purpose arrangements to meet specific customer requirements.

We do not use out-dated models of prime contractor relationships that reduce choice and flexibility in the market and create bottlenecks between our customers and the niche support they require.

Entrusted Group

Independent Sector Provider

Chairman: Stephen Day

1. What CSSs will you provide over the next 12 months?

Entrusted Group has a number of vehicles via which it delivers services to different areas of the healthcare system. Through our joint venture GTD Entrusted, we have three main areas that we focus on for commissioning support: governance, contracting and commissioning, and business support.

Governance support is around maintaining and providing an integrated and receptive approach to quality assurance, regulatory compliance, risk management and incident reporting. We also focus on the clinical commissioning group (CCG) responsibilities around freedom of information, data protection, patient advice and liaison services (PALS), symptom alert systems etc. to make sure that the CCGs are protected.

In contracting and commissioning, we will act as facilitator around contract management and negotiations. We can put together individual spending requests and work on procurements for any qualified provider and assessments facilitation.

We can do market analysis and give them a service improvement and development around contracting and commissioning; we can help sort out where there is a wrong pathway

with analysis and procuring to those pathways, and make sure they have got enough funded healthcare that they may need as well.

Finally, in relation to business support we can offer market analysis, programme and project management, communications and engagement, HR and organisational development (OD), finance and data analysis. We also have a number of support areas; we can pick up the volume if they have a volume issue in getting things managed, do crisis management and media management, help with corporate communications and their OD strategy. There's quite a lot we do around training and workforce management including particular project management skills that they may need or require on a short-term basis.

2. How is your business structured?

Entrusted Group is part of Argendium PLC and is a consultancy with several subsidiaries and joint ventures within the healthcare sector, including GTD Entrusted, Shaping Health International and aVida Care, through which we deliver commissioning support, health consultancy and health and social care services.

Within GTD Entrusted we have the head of contracting and commissioning and then a team of people who specialise in the various

areas of support we offer. We've got a very flat line structure to keep ourselves very much focused on the job in hand. Because we are private sector we do not necessarily need to have some of the structures that the NHS might have for a similar role.

3. What is different about your organisation, and why should commissioning organisations come to you?

I think what is probably different is that we have not filled it full of ex-NHS primary care trust people. We have brought people in from the NHS as well as a number of people from the private sector to help provide a more commercial and objective view than our competitors, which can be some of the commissioning support units (CSUs) or organisations who have a different skill set to us. We have got more of a commercial outlook being from the private sector. At the same time, one of our main strengths is that we're clinically led; there are a number of clinicians on the board and working within the organisation. Our aim is to provide the best clinically led solutions that provide easy understanding for our clinicians to be able to act on them.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

In terms of the challenges commissioners face, as in almost every area of modern life, they are being asked to provide more for less. The combined effects of an ageing population, higher demand for services and technological advances in treatment are putting increasing pressure on financial resources. At the same time, there is a clear expectation from the public of higher standards, not just of care but of transparency and accountability, particularly in the wake of events like Mid Staffordshire. Commissioning support adds value by ensuring the maximum return on every healthcare pound spent through better contracting and procurement processes. Better governance mitigates against risk while ensuring an efficient and effective provision. Better business support solutions drive effective organisational change and provide timely, accurate data to inform

Facts and figures

Number of dedicated staff in the healthcare team: 10 dedicated staff, with more than 35 specialist associates with a healthcare background

Current CCG, CSU and other NHS customers: Warrington CCG, North Durham CCG, St. Helen's and Wigan CCG, Calderdale CCG, Cumbria CCG; Tameside and Glossop CCG, Oldham CCG, NHS Central Manchester CCG, NHS North Manchester CCG, NHS South Manchester CCG, NHS South Sefton CCG, NHS Southport and Formby CCG; Cheshire and Merseyside CSU, Greater Manchester CSU; NHS Gloucestershire, West Hertfordshire Hospitals NHS Trust, NHS East of England Ambulance Service

Percentage of income from NHS contracts: 75%

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: About 20%

Service coverage/types of service provided: Commissioning support services: governance, contracting and commissioning, business support; healthcare-related consulting; delivery of NHS Productive series of programmes (LEAN); organisational development & leadership development for healthcare; domiciliary care.

Main competitors: Attain Commissioning Services, UnitedHealth UK (Optum Health and Technology), Newton Europe Ltd, the Lamberhurst Corporation

the commissioning process. This empowers commissioners to achieve goals and meet targets, from securing quality improvements against the NHS Outcomes Framework to addressing the local quality, innovation, productivity and prevention challenge and meeting the requirements for high impact innovations set out in *Innovation, Health and Wealth*.

5. What partnerships or planned partnerships do you have? Who does your network include?

Our joint venture GTD Entrusted has been born out of our four-year partnership with GTD (GoToDoc) Ltd, a not-for-profit primary care provider across the Manchester and Liverpool areas. As well as combining the expertise and experience of the two partner businesses, GTD Entrusted is also aiming to develop collaborative partnerships with CSUs to provide supporting services to the CSUs' service priorities for their foundation CCG customers. We are also looking to develop a relationship with NHS Improving Quality (NHSIQ) which would build on our joint venture Shaping Health International's work with their predecessor organisation, the NHS Institute for Innovation and Improvement (NHSI). We are looking to work with NHSIQ in further developing and refining team and leadership development programmes which diffuse best practice and increase productivity across the primary care, acute, mental health and community sector. Finally, we have built up a large network of contacts through our work for primary care trusts, strategic health authorities, CCGs and CSUs over the years, giving us access to a wide pool of expertise to call on for the provision of commissioning support services.

6. What are the major challenges of working as a provider of CSSs?

I think one of the key challenges for us is that what we provide in terms of support services allows them to get value for money; there are a number of people out there who can provide services, but whether they are providing value for money or not is another matter. Also, I think part of it is making it performance led

Biography

How does your career so far help you in working with the NHS?

With financial pressure on all areas of the NHS only likely to increase in the future, knowing how to make the best use of financial resources is vital to delivering the new model of patient-focused care; fortunately my past career as a financial and commercial director means that's something I have in my blood. Over the past seven years I've had the opportunity to work throughout the NHS, with PCTs, acute trusts, CCGs and CSUs, so I am to some extent an insider, with an in-depth understanding of both the system and the culture. At the same time my continued involvement in the commercial sector means I can bring a sense of perspective and a wealth of fresh ideas to the table.



What attracted you to working in this area?

What really attracted me was actually working in the NHS without being in the NHS because of the politics. So, generally I have tried to help turn things around, help people save money, communicate properly and to add value without having to be in a post that meant that I was stuck supporting one thing.

What do you enjoy doing outside of work?

I enjoy going on holidays, property development and I have a couple of horses.

so that there are performance criteria around services provided. The other challenge relates to the fact that the NHS will keep changing or the landscape will keep changing, and it is how to keep ahead of that. This involves market analysis, understanding our patients and how the demographics will change, and developing the best solutions to make sure that care continues to be delivered in a safe way.

7. How do you see the CSS market evolving?

I think over the next 12 to 18 months all the current contracts could potentially be up for re-tender by the CCGs and so the market will be opened right up. I think there will be quite a lot of competition and that the NHS will turn out the current CSUs into the private sector and let them become a social enterprise. At that point, it will be quite a free and open market with CSUs and the independent sector competing side by side and more independent sector organisations springing up. I guess that will lead to more performance driven organisations rather than the currency issues that basically

contain ex-NHS people from PCTs that have been brought together regionally, and will now allow them to be more competitive.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

I think that broadly we have the range of services to lead, but if there is anything out of scope then we could look at that at the time. As for partnering, if there is an opportunity to partner to get better benefit and value for client, then absolutely.

IBM UK

Independent Sector Provider

UK and Ireland healthcare industry leader: June Thomson

1. What CSSs will you provide over the next 12 months?

We see ourselves as working with commissioning support units (CSUs) to optimise IT services for clinical commissioning groups (CCGs) rather than working in competition with CSUs.

Our focus is on how to use information better which includes better visualisation of data, such as bringing dashboards more up-to-date and real-time rather than retrospective, and looking at predictive analytics, which allows future needs to be anticipated more accurately, rather than relying on extrapolation of past trends. We can both provide the technology and advise on the business change required to benefit from the technology to help CSUs enable their end customers, such as CCGs, to drive better care at lower cost. We also offer a business process outsourcing service delivering things such as HR, payroll, finance, customer relationship management and procurement, with the added benefit of best practice from other industries. In the area of predictive analytics, advanced tools such as IBM's Watson and our patient care and insights solutions can also potentially make significant contributions in the future. Watson is a system built in IBM Research that uses natural language processing to make sense

of text and other unstructured information found in journals, textbooks, patient records, treatment and outcomes, and doctors' notes. Based on analysis of such unstructured data, advanced tools like Watson could allow commissioners to make predictions about a range of outcomes including which patients have a higher likelihood of contracting multiple long-term conditions, which in turn informs commissioning decisions and investments. Given that the data used in healthcare planning at the moment, which is mainly structured data, constitutes only 20% of available data, unstructured data offers a lot of potential to drive commissioning, including taking into account social and behavioural factors for a patient. Currently, we have a pilot running at the Memorial Sloan-Kettering Cancer Center in the US, which uses Watson to guide oncologists on possible treatment options for patients.

2. How is your business structured?

We have healthcare experts in many parts of the world, and we are connecting our UK and Ireland team with them to bring best practice and help us deliver innovation into the NHS in UK and Ireland. We are putting together a team to look at specific solutions for CSUs to help them in what they are trying to deliver to CCGs. We also have industry

specialists, technical resources and experts in research and development (R&D) that client and business development executives can bring together to address the specific needs of our clients. With healthcare as an industry transforming to become more patient-centered, it is valuable to bring those lessons from other industries such as retail, which is extremely customer focused.

3. What is different about your organisation, and why should commissioning organisations come to you?

As a global health organisation which has invested heavily in R&D, as well as cross-industry experience, there is a lot of best practice that we can bring to commissioning, especially in the area of transformation. This includes for example, integration of health and social care systems, implementation of digital hospitals, predictive analytics and business process outsourcing, using IBM's experience elsewhere around the world.

We have many good examples of where we have delivered absolutely tangible improvements to the healthcare organisations that we have worked with, including organisations in Spain, the US, Canada, Denmark and Sweden. For example, a healthcare organisation has lowered hospital readmission rates by using unstructured data and predictive modelling to identify patients most likely to be readmitted to hospital. Currently, in the UK, we are working in the spirit of partnership with one CSU to build a pilot system to improve the way that CCGs use data to make better decisions on behalf of the patients they are commissioning care for.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

CCGs have a financial challenge, arising from the increase in the cost of care through inflation combined with the fact that the budgets are largely flat for the NHS. It is about how they create those efficiencies so that they have the necessary funds to deliver care at the same or at a better level, over

Facts and figures

Number of dedicated staff in the healthcare team: undisclosed

Current CCG, CSU and other NHS customers: IBM provides software and hardware products to many NHS England organisations, as well as NHS Wales, NHS Scotland and NHS N Ireland

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: There are three service groups: business consulting services - including hospital transformation, eHealth, digital front office and analytics; IT Services - including outsourcing, cloud and strategy; and business process outsourcing. IBM also provides a wide range of software, storage and servers to healthcare clients. The integration of patient data, building patient portals, creating a trusted single patient record, reporting and analysis of hospital information and the optimisation of patient pathways are amongst services enabled by IBM software in the NHS

the next few years. Enabling them to realise those efficiencies is a role for the CSUs and one that I think we can support. We can provide technology which enables change, and we can advise on how to make that change. Technology-enabled transformation is something that we understand well and is a key enabler for achieving those efficiencies. CSUs also have a role in providing the support capabilities such as IT, HR, procurement and finance so that CCGs can focus on their *raison d'être*.

5. What partnerships or planned partnerships do you have? Who does your network include?

We have built a strong network of partners, and there are many areas where we work in healthcare with other organisations.

Furthermore, we are absolutely not averse to working with companies who might be viewed as our competitors, such as other systems integrators or consultancy companies. We will form partnerships to better meet client needs. For example, we worked on the NHS employee staff record system with McKesson and Oracle. We also supply technology in the form of software and hardware to many of the major NHS contractors.

6. What are the major challenges of working as a provider of CSSs?

CSUs are new organisations which have needed to make the transition from working with colleagues in the old system to serving them as customers. Furthermore, they now need to get used to a model where they are in competition with each other as well as more open competition in the ensuing years, which is a different model for people that have been public servants until now.

It is not only a challenge, it is also an opportunity for the ones who are more entrepreneurial and have the right vision and customer ethos. Organisations such as IBM with experience outside the public sector can play a very useful role in working with them to understand that environment and to develop their commercial skills.

A challenge for us, as providers as always,

Biography

How does your career so far help you in working with the NHS?

I have a good understanding of the public sector from working with public sector customers such as the Civil Aviation Authority and the Royal Mail group while at IBM. Then I was the client executive for the NHS during the National Programme for IT, so I really got to know the NHS then. I have also spent time working in manufacturing, research and development and sales and marketing within IBM, providing me with an overall understanding of the different stages impacting customer care. I have been in my current role since July this year. Prior to this, I was sales director for our business partner organisations, helping our business partners sell into all sectors, including the public sector and NHS.



What attracted you to working in this area?

This is an area that I'm very passionate about as it can really make a difference in people's lives. It's also an area where data analytics can make major transformative changes.

What do you enjoy doing outside of work?

I have four children ranging from 11-22. My kids are very sporty including one who's a gymnast for the England B team and another who plays tennis professionally, and so I do a lot of sporty things with them. I enjoy running and going to the theatre.

is understanding customer requirements. So it's about understanding CSU requirements and their end-customer's requirements. In an evolving market, this can be difficult as they are themselves still discovering what those requirements and needs are. For our part, we have to try to anticipate so that we can seek to constantly be relevant to them as a supplier, so that they grow to be essential to their clients.

7. How do you see the CSS market evolving?

As time goes by, you will begin to see where the areas of best practice are. Some CSUs may share best practice, and there are likely to be mergers. This will lead to economies of scale - if somebody is doing something really efficiently, really cheaply and delivering a quality service, why not expand that? CCGs may commission support in one area from one CSU, and support in other areas from another CSU.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

For now we are much more likely to work with partners and support other organisations, rather than lead.



Independent Sector Provider

Associate partner: Gary Belfield

1. What CSSs will you provide over the next 12 months?

Our support is based around organisational development of the commissioning support units (CSUs), helping them to be more commercially aware to add value to clinical commissioning groups (CCGs). We are also undertaking work with CSUs and CCGs to help them with their current and future quality, innovation, productivity and prevention (QIPP) plans, and working with CCGs to help them with their commissioning intentions for 2014 as well as primary care development. Strong primary care in GP practices will help move services in hospitals into the community. All of this is underpinned by strong commissioning intelligence expertise that we bring to commissioners. This brings a crucial focus on the patient and quality which is at the heart of our philosophy.

We will maintain focus on supporting QIPP delivery because of the financial pressures in the NHS and increase focus on transformation of the health economy due to strong clinical and financial links within KPMG. That will include transformation through integration with local authorities.

2. How is your business structured?

KPMG in the UK is a leading provider of professional services including audit, tax and advisory. As part of KPMG Europe LLP we are part of the largest integrated accounting firm in Europe. The commissioning team sits at the heart of the health team within the public sector group. Within the commissioning, we have worked with a quarter of CCGs and 12 of the 18 CSUs in the last two years. The structure of the commissioning team changes depending on the needs of the customer. While we have a health core, we bring in experts from other fields within the company as and when we need them. For example, I might be able to bring in someone who's worked in the retail sector to bring in a solution they've used in the past and apply it to health such as in the area of customer engagement. We can also bring in expertise from our range of partnerships providing me with access to 200 or more people within 24 hours.

3. What is different about your organisation, and why should commissioning organisations come to you?

KPMG are different for three main reasons.

Firstly, a number of the core team have NHS backgrounds or extensive experience of working in the NHS. This makes clinical engagement easier and embeds the NHS into our core values.

Secondly, we bring to commissioners different skills and experiences from across our vast range of partnerships, the range of which I believe no-one else has; this is a really important part of our 'commissioning one stop shop' offer. The third is that I believe our core values are probably more closely aligned to public sector organisations than some of our competitors in terms of style and approach. For example, we give people time off each month to do volunteer work such as supporting Shelter. We are also very strong on leadership development, and recently, we have been awarded the contract to provide leadership support to the top two layers of the NHS over the next three years in partnership with Harvard, Birmingham University and other renowned organisations.

We also have a strong business intelligence team who have been very successful in helping to translate data into really good information for commissioners so that they can make informed commissioning decisions. And then I think we are really strong on the whole system transformation – or care system redesign – such as hospitals, community services, local authorities all coming together to improve health. With financial management being the background to KPMG, we can help the taxpayer get the best value for money and make sure that every pound is spent as effectively as possible while being really focused on the patient.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

Commissioners face the dual challenge of improving the quality of service outcomes and achieving value for money for taxpayers. Even though the NHS is being protected by the government, they have been used to rises in recent years of 4–6% and at the moment it is close to zero, so commissioners will have to make some hard decisions. Another challenge is the fact that clinical commissioning groups

Facts and figures

Number of dedicated staff in the healthcare team: 200 plus

Current CCG, CSU and other NHS customers: Heywood, Middleton and Rochdale CCG, Oldham CCG, Salford CCG, Stockport CCG, Tameside and Glossop CCG, Trafford CCG, Wigan Borough CCG, Stafford & Surrounds CCG, Cannock Chase CCG, South East Staffs & Seisdon Peninsula CCG, Stoke on Trent CCG, South Staffordshire CCG, North Staffordshire CCG, Bucks CCG, Middlesbrough CCG, North Tees CCG, Hartlepool CCG, Principia Rushcliffe CCG, Newham CCG, Sutton CCG, Wandsworth CCG, Hounslow CCG, City and Hackney, Castle Point & Rochford CCG, Thurrock CCG, Basildon & Brentwood CCG, Milton Keynes CCG, Nene CCG, South Worcestershire CCG, North Manchester CCG, Central Manchester CCG, South Manchester CCG, Bolton CCG, Bury CCG, Lewisham CCG, Kingston CCG, Bromley CCG, Southwark CCG, Lambeth CCG, Richmond CCG, Haringey CCG, Croydon CCG, Barnet CCG, West London CCG + 54 others; 12 CSUs among other NHS customers

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: All commissioning services from CI through to OD

Main competitors: undisclosed

are very, very new, yet a lot is expected of them. This is linked to the third point which is that if you look back over the last 20 years, commissioning has been reorganised about every three years, and so there is an element of doubt as to whether they will have time to grow and mature and effect change before everyone wants to re-organise them again, so that is a worry.

Commissioning support can therefore add real value by working alongside commissioners in these three crucial areas of improving outcomes, managing the resources and bringing system knowledge to help CCGs through the 14/15 contract round.

5. What partnerships or planned partnerships do you have? Who does your network include?

We have had a strong partnership approach for three years. The core of the partnership are Healthskills, UnitedHealth, National Association of Primary Care, Primary Care Commissioning, and Morgan Cole, which is a legal firm. So we have got access to a couple of hundred experts at the drop of a hat to then help meet any commissioning needs. In addition we have been the most successful company accessing the Consultancy One framework. This brings commissioners another 70 or more partners to meet all their commissioning needs. Our feedback from clients is that this adds real value to local commissioning decisions.

6. What are the major challenges of working as a provider of CSSs?

Providers will have to differentiate themselves from others, to stand out with a great service offer. I think that is a challenge for the 18 CSUs. The next challenge is how CSUs add even more value for money as their income is likely to get squeezed as the financial pressures become more acute, which probably means more greater use of technology. And the third challenge will be how to provide commissioning support to relatively young CCGs who do not always know what they want?

7. How do you see the CSS market evolving?

I see CSUs consolidating to provide greater

Biography

How does your career so far help you in working with the NHS?

I had 18 years working in the NHS. I spent about two thirds of that time working in hospitals, including as an acute trust chief executive, and about a third of my time in community, mental health, primary care services. So I am well equipped in terms of my knowledge of the health sector from that point of view. I have been head of commissioning within KPMG for three years and before this, I was director general of commissioning and system management at the Department of Health including being a member of the NHS management board. I am a faculty member of Institute for Healthcare Improvement (IHI) and a Cohort Director for the Bevan Programme at the NHS Leadership Academy.



What attracted you to working in this area?

If we are really going to change the way the NHS works and improve population health, we need fantastic commissioners, which means great CCGs. For them to really do their job properly, they need brilliant support behind the scenes. So I see KPMG's role as working with CSUs to help them deliver great support for the CCGs to allow the CCGs to focus on the really important clinical and population health issues.

What do you enjoy doing outside of work?

I like cooking and have an eclectic taste in music. I was born in Manchester so obviously I am a Man City fan. My wife and I travel a lot and we are godparents to lots of children who we like visiting and spoiling.

scale and value for money for commissioners. There may also be greater division in responsibilities, for example, if we take mental health commissioning, maybe three or four CSUs can do that on behalf of everyone else providing more concentration of expertise and better value-add. There is also likely to be a move away from geographically defined CSUs.

As for the independent sector, I can see some interest, but some companies look in and think the NHS has not had a great history in encouraging market entry. So there might be a bit of reluctance to come in until people realise that NHS England is serious about having an open market. I can see that there are independent sector organisations out there that have strong offers that would absolutely benefit the NHS. So while I really hope that parts of the market do grow, it is still very much a publicly funded and provided NHS at heart which I strongly support. How the CS market develops will also depend on the appetite to move towards more integration between local

authorities and CCGs, but we will have a closer idea post the next elections. Obviously, the appointment of the new CEO for NHS England will also have a crucial impact on direction.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

We will definitely be bidding to be on the framework as a partner with CSUs. I just think it is better for the NHS if we align the skills and experience within KPMG with really great local knowledge and great NHS values from CSUs.

LEK Consulting

Independent Sector Provider

Partner: Eilert Hinrichs

1. What CSSs will you provide over the next 12 months?

Historically, our work has been weighted towards the private sector, focused on strategic advice and assessing markets trends and dynamics from a commercial perspective, which are very pertinent in today's healthcare sector. These skills are very much applicable and are also getting more important in the public sector. On behalf of our clients we are interacting with clinical commissioning groups (CCGs) and commissioning support units (CSUs) on a weekly if not daily basis and I would expect this to continue in the near to medium term. Therefore we have a very good understanding of the key commercial and strategic issues and challenges that CCGs are facing. In the commissioning support space, I could see us advising on a range of topics including overall commissioning strategy, the required transformation agenda (organisationally as well as from a market perspective), on provider strategies and the provider selection process.

With our extensive experience with the private sector, we understand how they like to engage and would be able to bridge the gap between CCGs and the private sector and help to identify where private providers can add the most value. Being rooted in a rigorous analytical approach, we could also assist with business intelligence, helping commissioners to underpin and substantiate decisions with analysis and data.

2. How is your business structured?

LEK Consulting is a global management consulting firm that uses deep industry expertise and analytical rigor to help clients solve their most critical business problems.

We have six partners in our wider European healthcare practice, who would be able to provide commissioning support. Our healthcare team comprises 25 consultants with very deep experience within healthcare, in addition we have a global network and a pool of 200 professionals in our London office whose expertise we can draw on. Our partners are very hands-on and typically client engagements are led by two partners, who are being supported by an engagement manager who runs the day-to-day management of the case. The senior team members are supported by a right sized team of analysts, this approach provides us with the flexibility to support clients with issues of any size.

3. What is different about your organisation, and why should commissioning organisations come to you?

We would bring a deep and profound understanding of the private sector including how private providers like to engage with the public sector as well as where and how the private sector can provide the most value-add.

Defining the overall commissioning strategy and the transformation agenda

are two areas that would benefit specifically from our understanding of the private sector and our rigorous data driven approach. We are able to provide CCGs with a framework against which they can set key decisions and prioritise objectives. For example, if managing the chronic obstructive pulmonary disease population is a key need, an analysis of available resources might also draw attention to the need to increase providers and how to satisfy this need. Without a robust framework, CCGs run the risk of taking decisions that are inherently inconsistent and misaligned, and therefore will not stand the test of time.

With regards to our work in the private sector, LEK Consulting is one of the leading providers of strategic advice and our contribution has been recognised by a number of awards including strategic consultant of the year in 2013 and 2011, M&A advisor of the year in 2012; Laing & Buisson consultant of year in 2012. We are providing advice to companies who basically operate along the whole patient pathway and healthcare value chain, including primary care, diagnostic imaging, in the interventional space as well as the hospital space and providers of private medical insurance. Our clients regard us for providing commercially savvy, still practicable and executable advice and the high level of engagement of partners in the engagement.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

One of the key challenges we hear on a regular basis, is how to define 'best practice'. It is easily defined in some areas but less so in other, for example, in the management of chronic diseases with a wide range of patient pathways and settings. It is complex to determine when and how to engage with the private sector and when should provision remain in the public sector. Some commissioners also struggle with prioritising their commissioning strategy to drive efficiency and savings. A common approach that we observe is tackling 'low hanging fruits', even if cost savings are likely to be limited. I think it is important to set strategic priorities that are rooted in data, that can be evidenced

Facts and figures

Number of dedicated staff in the healthcare team: 25

Current CCG, CSU and other NHS customers: None

Percentage of income from NHS contracts: 0%

Percentage from other health contracts: 100%

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: 10-15%

Service coverage/types of service provided: Overall strategy, growth strategy; market entry strategy; business intelligence; transaction support services, Commissioning support (Strategy advice: prioritisation of treatment areas, facility footprint, provider selection; define transformation agenda; develop provider strategy; develop performance measurement framework; improve organisational effectiveness)

Main competitors: BCG, McKinsey, healthcare teams of KPMG and PWC

and that are pragmatic. Other areas of difficulty that we observe include how to best incentivise the integration of commissioning, funding and provisions of health and social care, how to move to outcome-based commissioning and how to define what good outcomes look like. There is also a scale issue, a number of CCGs are simply not large enough to be able to negotiate with large foundation trusts effectively. The commissioning-imbalance is one issue and whether they are right-sized to manage the needs of whole health economies is another issue and I would expect some consolidation.

5. What partnerships or planned partnerships do you have? Who does your network include?

We tend not to partner with other service providers because we are engaged to address a specific strategic issue for which partnering is typically not required. This approach helps us to control quality, which we are fairly obsessive about. However, we are often working alongside other advisors who have adjacent but different skillsets, for example, in life science or transactions, and we are comfortable doing that.

6. What are the major challenges of working as a provider of CSSs?

Historically, there has been a problem with our lack of a track record of working with the public sector, which has led us to focus on the private sector rather than the public sector. While the redefining of the commissioning landscape seems to have led to a greater willingness to engage with the private sector, we do not know whether CCGs and CSUs will continue using public sector experience as a key selection criterion. Further challenges to establishing our market presence include a clearer understanding of key buyers and their buying behaviour, and the size of projects, engagements in the £50,000-60,000 range are too small because the economics do not work out for us, yet, if the project is too big, for example, requiring 50 professionals on the ground, we may not have the resources to respond adequately either.

Biography

How does your career so far help you in working with the NHS?

I joined LEK. 16 years ago, and having interacted with the NHS and CCGs and CSUs over the last ten years, I have a very good understanding of their key challenges and commercial issues. Having also worked with the private sector, which is typically more efficient and outcome focused, I can relay between those two, and I think I am well prepared to add value.



What attracted you to working in this area?

It is one, if not the biggest, challenge of our society to create a healthcare and social care system that is fundable, sustainable and that provides a service that is as good as the one we are experiencing today. The transition will take us a long time and helping to shape this evolution is rewarding and intellectually stimulating.

What do you enjoy doing outside of work?

Cycling, skiing, hiking, cooking and spending time with my two boys and wife.

7. How do you see the CSS market evolving?

There is a significant need for change and transformation, which should result in a growing demand for advice and support from CCGs. The value creation potential is huge and could easily pay for first class advice. However, the level of engagement of the private sector remains to be seen and will depend on the openness of the CCGs to take advice from the private sector.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

We would have to evaluate such an opportunity on its merits, and as this is not our normal approach we would need to discuss this with our fellow partners.

McKesson Shared Services

Independent Sector Provider

Director of operations: Mark Dolman

1. What CSSs will you provide over the next 12 months?

We provide outsourced shared services including payroll, pensions and the transactional side of human resources for all the commissioning support units (CSUs) and six clinical commissioning groups (CCGs) that come under one of the CSUs. Our job is very much to ensure that everybody gets paid accurately and on time so that they can ultimately do the role that they have been employed to do. We operate a sustainable business model, developed on the foundations of continuous improvement; so we work in partnership with our customers and have created a service which has the potential to evolve in line with their needs and requirements.

2. How is your business structured?

McKesson Shared Services (MSS) belongs to McKesson's UK Workforce Solutions Portfolio. We have two shared service centres both here in the UK; 13 teams providing HR, payroll and pensions services to more than 50 NHS organisations. We have payroll, pensions, processing, HR and admin teams who all work together to deliver a comprehensive and seamless service to our clients. All our senior management teams have extensive NHS payroll experience, so we know how complex it really is. We have dedicated customer relationship managers and we also provide dedicated telephone numbers, email addresses and customer portals which allow employees to log queries with us 24/7.

3. What is different about your organisation, and why should commissioning organisations come to you?

I'm not one to make comparisons but prefer to concentrate on what we need to do to deliver a high quality service and to best meet customer expectations. This means working closely with customers to understand how our services can be tailored to their needs and also constantly looking at ways to improve the client experience so that people do not need to think about what their pay may or may not look like and can just focus on their roles.

We have a unique selection of services, solutions and capabilities designed to accelerate the benefits of the electronic staff record (ESR). This means that MSS clients have access to project managers and implementation consultants with unparalleled knowledge of the intricacies of NHS payroll processes.

We are looking towards a completely paperless system, which would have a number of beneficial effects. As well as being much more environmentally friendly, it would also be quicker and smarter, eliminating errors resulting from the interpretation of handwriting and improving the way documents flow through from employees to managers and then all the way into the system directly which would allow a better checking process. It is quicker than relying on people photocopying things and storing lots of paper and there's less likely to be delays due

to post. In turn this means that cut-off dates can be extended and people are more likely to get things in on time. Based on that principle, other innovative solutions we have include the electronic absence tool, time sheet and expenses solutions. By allowing absence information entered on a device to flow through to managers directly, it gives managers visibility of overall absence and allows better workforce management. We have an enormous amount of experts as well as great knowledge and experience that surpasses others in the field. We have a track record of implementing systems at scale such as the ESR Project – the world's largest integrated HR and payroll solution. When I started work on the ESR eight years ago, all the organisations were on their own individual systems, and we amalgamated all the systems into one single solution on behalf of the NHS, so you are talking about 1.3 million people, thereabouts, being put onto that system.

McKesson has been a stable partner, advisor and innovator to the NHS for more than two decades, and we are proud of that. We have made a major commitment to the NHS, our products and services have made a real difference to healthcare in the UK. Our customers have told us time and time again that we are a trusted partner who delivers reliable and proven solutions.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

We are not really part of that space as we are providing business support functions under a contract by NHS England. In general, being newly established, CSUs have gone through a lot of change; people have moved around a lot and they are structurally different from before so there will be issues around organisational development. From our perspective, we want to make sure that payroll is the least of their worries so that they can focus their energies on settling in.

5. What partnerships or planned partnerships do you have? Who does your network include?

McKesson are working in partnership with

Facts and figures

Number of dedicated staff in the healthcare team: 120 (all MSS staff)

Current CCG, CSU and other NHS customers: 52 organisations including ALBs, CSUs, CCGs, foundation trusts, ambulance trusts, social enterprises, mental health trusts

Percentage of income from NHS contracts: 100%

Service coverage/types of service provided: payroll, pensions and HR transactional services

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: 20% payslip production growth

Number of dedicated staff in the healthcare team: 120 (all staff)

Main competitors: Capita, SBS, ICS Equiniti, UHB

Logic CGI to deliver fully managed payroll services to the Department of Health's arms length bodies (ALBs) through the government procurement services (GPS) framework.

We also work with Software Europe to provide our customers with 'expenses health' the leading online expenses management solution for the NHS.

We were one of the first private sector organisation to be awarded the payroll quality partnership (PQP) accreditation from the Chartered Institute of Payroll Professionals (CIPP). This prestigious and independent accolade demonstrates our continued dedication to providing our clients with the highest level of value and service possible through effective payroll learning and development.

We are also an Oracle Platinum Partner which recognises our on-going technical innovation and leadership in the healthcare sector.

6. What are the major challenges of working as a provider of CSSs?

The NHS is constantly evolving, and its needs and requirements change to reflect this; and so must the solutions and services that we provide. It is important to remember that we are dealing with brand new organisations, and the people in these organisations have been subject to unprecedented levels of change.

With the CSUs being so geographically spread out, communication can be a bit of a challenge. While there needs to be some degree of standardisation to make sure that communications and the quality of our work is consistent, we also need to respond to local needs that each CSU has. With the CSUs being newly established, it becomes especially complex with regards to the information that needs to be provided. The quality of information that we're provided with is such a key part of overcoming the challenge, and it has been a learning curve for both sides. We've been working very closely with the CSUs and NHS England to make really good progress on this. I believe that with the lessons learnt from all our other customers, we will find a path to getting the right messages out to all of the right people very quickly.

Biography

How does your career so far help you in working with the NHS?

I have had a lot of experience in dealing with customers on the operations side of things. When I first joined McKesson, I worked as a programme manager of ESR implementation which involved putting about 1.3 million people on the payroll system. Then I moved across to applications support manager, where I was responsible for supporting all the key contacts in all the NHS organisations with regards to general payroll queries as well as about the system itself. And then three and a half years ago, I moved on to McKesson Shared Services in my current role.



What attracted you to working in this area?

It was time for a change. When the opportunity came up, it was something I really wanted to try. At the time, I was working at Motorola travelling around Europe and implementing logistics inventory solutions for the microchips, and I felt that it was an opportunity to apply my skills to an area of great significance as the NHS is the largest payroll system in the world.

What do you enjoy doing outside of work?

I like spending time with my family and going camping. I have two daughters who are 12 and 10.

7. How do you see the CSS market evolving?

The CSUs are still trying to settle and everyone is still trying to put their feet firmly on the ground before deciding what the next step is so I think it's too early to tell how things will work moving forward. From my understanding, there will be competition among the CSUs.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested this?

This doesn't really apply to us as we're covered under a separate contract under the NHS England to provide payroll services for CSUs whereas the model applies to CCGs looking to source products to serve local communities.

Medical Mosaic

Independent Sector Provider

Director: Robin Stern

1. What CSSs will you provide over the next 12 months?

Our current services include service redesign support, clinical commissioning group (CCG) IM&T strategy development and helping to develop the business readiness of commissioning support units (CSUs)

We've also done quite a lot of back office work including information and tailored IT strategies for the new CSUs who have inherited a somewhat ramshackle kit of parts from primary care trusts. We have also been supporting a CSU in making the right decisions in implementing clinical risk management systems.

The main area that we see as dominating our work in the longer term is health and care integration, through providing commissioners with the tools, metrics and a way of working to examine real detail to achieve integrated care. In this regard we have developed a framework called persistent innovation product set (PIPS®).

It is as much a mind-set as a product-set, with which we will equip CCGs and CSUs with the capability to take it on themselves. Of immediate importance is the urgent care agenda. We can help CCGs develop and structure themselves to deliver a better services and reduce pressures, through using PIPS® in a transformational way combined with the MSP/PRINCE 2 project management approach.

2. How is your business structured?

Medical Mosaic is an experienced consultancy, facilitating targeted improvement to clinical productivity, through business change and technical support.

There are ten of us, half employed, half associated. Our primary skills base includes transformation, informatics, finance, engagement and clinical – all senior people. In addition we work with more occasional associates, who bring us wider skills and, of course, capacity. The PIPS® framework binds all of those things together for commissioners (information flows, financial flows, clinical activity models, patient experience and outcomes) so that we can see how everything works together in one coherent way – whether in the 'as-is' or 'to-be' scenarios, applied to back-office or service delivery situations.

3. What is different about your organisation, and why should commissioning organisations come to you?

Some of the business readiness work we've done for Staffordshire and Lancashire CSU includes time-recording, customer relationship management (CRM) and developing an IM&T strategy, aligned with its CCGs' needs and its own driving business strategy. As one services provider assisting another, we were able to add the value we

had accumulated from 18 years in business in respect of basic systems and processes.

One of our differentiators is that we have defined a model such as PIPS® which allows a whole-systems approach and also the handling of detail at the component level. Our talent is that we have not bred generalists, but specialists who work together. As part of skills transfer, we show our customers what we do and talk them through solutions giving them examples.

While there are many apparently obvious and significant service improvements that can also save a lot of cost, there are many perverse incentives in the system that unbalances the rewards, which we have experience of managing. For example, transferring more care from hospital to community may be a better pathway clinically and cheaper overall. But if a specialist services commissioner takes all the saving and the local CCG and the providers merely face added cost pressures, things do not always add up. Ultimately, solutions may lie in looking at the widest possible sense of whole system which does not only include community and hospital, but also intensive care, high dependency, primary, secondary and tertiary care.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

One would hope this does not happen but the runes are there for them to carry a lot of responsibility that is not matched by the authority needed to fulfil it, in balancing their books while achieving major service changes. There are challenges of ageing populations and managing long term conditions: the need radically to re-engineer care models and issues of information governance that require resolution to enable such models.

Good commissioning support will equip them with the tools and skills needed to exercise local leadership to punch above their weights – including dealing with NHS England or NHS Employers/local area teams/health and wellbeing boards. Having command of the evidence base and being able to use it with clarity of purpose will be of value.

Facts and figures

Number of dedicated staff in the healthcare team: 10 plus associates

Current CCG customers: Cannock Chase and Stafford and Surrounds CCGs

Current CSU and other NHS customers: Public Health England, Staffordshire and Lancashire CSU, contracts with NHS trusts and contracts with third sector and voluntary sector organisations

Percentage of income from NHS contracts: 90%

Percentage from other health contracts: 10%

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: none

Service coverage/types of service provided: strategy development and alignment, remodelling care pathways, planning service integration, developing business intelligence capabilities, and creating winning business cases for investment in IT

Competitors: undisclosed

5. What partnerships or planned partnerships do you have? Who does your network include?

Our partners whom we would call upon include InMedical Limited: technology provider for big data management and analysis, Planned Care Solutions Ltd: technology strategists, especially in enabling collaboration in health and care, Experis Manpower Group: interim resourcing across a wider range of skillsets, David Laszlo Partnership: culture change leads, 3E Europe: governance, risk and compliance systems. We also retain an open offer to CSUs to work in partnership with them, by providing services to their CCGs under their aegis.

6. What are the major challenges of working as a provider of CSSs?

Being an organisation of ten, the challenge for us is that of sheer scale and the only way we can address it is by being extremely good at what we do, making that known and developing a scalable service.

7. How do you see the CSS market evolving?

CSS providers need to get delivering, and quickly, otherwise CCGs will continue the trend of delivering more in-house as primary care trusts did before them.

One major change, depending on the next election, could be putting the commissioning budget under local government. This would have a major impact for CSSs. Local government is a hard bitten and mature set of commissioning organisations who know what they are doing, have had great experience at managing back office services and the sort of things that we are calling commissioning support services. Being skilled in knowing what to provide themselves, what to share among them, to do at scale, what to buy in externally,

I think their influence on the commissioning support services market would be very swift and probably quite brutal. Understanding the way they would work is something that current CSS providers ought to be thinking about.

Biography

How does your career so far help you in working with the NHS?

I have worked for the whole of my career in the NHS, or with it. I think it has prepared me well because I certainly understand the context within which we are working and I can see the continuum in the changes that have taken place. I learned from my very first job in Springfield Hospital in Tooting that to get things done, you need to involve the wider organisation and other stakeholders, as well as those at the coal face.



What attracted you to working in this area?

In my third year at Cambridge University, I felt I had become surrounded by people who knew an awful lot about an awful little, and I just did not want to be like that. The NHS was one of a few possibilities of a career where from the outset you can see the wood from the trees. However, if, as a consultant, you want something to offer others, then you need to have something specific. That did spawn the need to bring a lot of capabilities together by attracting and working with people aligned them in teams; but I have remained the generalist. I have found that to be essential if I am to remain aware of the boundary between the ideal and the achievable.

What do you enjoying doing outside of work?

I have just finished a Cambridge University history summer school and I completed an essay in conflict archaeology, applied to WW2: civilian internment, prisoner of war and concentration camps, respectively. What a lovely break to do something so completely different, if taxing. Thinking back to this year's family holiday to Sicily, I appreciated having started to develop a sense of place through understanding history, whether applied to when Sicily was part of Greece, or to more recent Mafiosi events. I think a course in the history of buildings is next.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

Because of our size, we are in no position to be a prime. Being part of a consortium that is offering services would be delightful. In the same way as we have built something which is a lot bigger than the sum of its parts, we can see how that would work with many other elements as well such as regional development of local tariff arrangements and supportive integrated care. This would involve some quite heavyweight financial analysis that we could work with. Another one would be turnaround on a big basis. If you have a whole region that has historical problems of funding, big 'P' political issues and needing to reshape and remodel, we can help to

understand how the econometrics measure up to produce a range of options for better outcomes of those services. Another area of strength is agenda alignment: systematically working out the engagement issues of who has what agendas, helping to focus on commonalities between them rather than on the differences.

Independent Sector Provider

Head of healthcare: Sian Rees

1. What CSSs will you provide over the next 12 months?

We have solutions in three broad and interlinked areas; patient engagement for care coordination, health analytics and back office services. Commissioning support units (CSUs) and clinical commissioning groups (CCGs) are already using Oracle software for HR and payroll -- via NHS electronic staff record (ESR) - enterprise resource planning (ERP), contract management and procurement through NHS shared business services providing a potential platform for planning and budgeting services.

In the area of patient engagement and care coordination, we will be bringing our international experience to bear, for example, a health system in Spain is using Oracle software to manage eight million citizens access to health care through a multi-channel contact centre. They have generated both system efficiencies but more importantly significant improvements in patient satisfaction. We will also be bringing our strong business intelligence capability (including free text and social media analysis) to market. We can advise on how data analytics and information systems can be used to support models of care that allow a more holistic view of the patient, which is a challenging area for clinicians. Currently, patients have the most complete picture of the various aspects of care they receive, as there is no comprehensive information

system in use that monitors the overall patient contact experience across health and social care. We aim to combine an element of self-help into information analytic models to present a cohesive picture of their experiences and help drive patient centric services.

2. How is your business structured?

Oracle Corporation is a global enterprise software and hardware provider. In addition we provide services and solutions to all business sectors.

Oracle structures its health and social care industry functions at a global level, enabling us to bring international experience and good practices to bear on local challenges. In the UK I coordinate more than 80 industry focused colleagues with commissioning as a key focus area.

3. What is different about your organisation, and why should commissioning organisations come to you?

We have a unique and proven offering around data and systems integration powerfully combined with our business intelligence capability. We are able to collect data from multiple sources and integrate that into a dashboard. Our systems capability combined with our strategy provides an integrated understanding of patient contact experience across different touch points and data sources. Our approach is to focus on

the points of interaction, consolidation and flow of information needed to deliver a total care pathway. Our model also introduces an element of self-help in allowing patients to add to the data to better coordinate their experience and for the sake of completeness. We have a track record of delivering similar tried and tested systems across many other industries, including banking and retail. In addition our back office functionality enables CCGs to manage the business cost effectively.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

The current focus on a federated NHS organisation carries the risk of data fragmentation and intelligence losses across the NHS, which has the potential to undermine the integrated system of care that commissioners are trying to achieve.

In addition the current levels of security provision limits the ways in which data can be accessed and there is the constant balance and measurement of value vs cost between which services should be commissioned with the limited funding available. It is by addressing these areas that we believe commissioning support can add most value.

5. What partnerships or planned partnerships do you have? Who does your network include?

It is pretty extensive and it covers many of the independent software vendors and systems integrators focused on healthcare. For financial services this includes NHS shared business services and NHS North east procurement (NEP). We also work with McKesson from an electronic staff record perspective.

6. What are the major challenges of working as a provider of CSSs?

Given the funding constraints for CCGs, the CSUs will be challenged to deliver new and potentially more competitive services, which could result in an imbalance between short and long term solutions. Our challenge will be to quantify the value of ongoing advances in technology and our experience in other parts

Facts and figures

Number of dedicated staff in the healthcare team: More than 1,000 globally and 80 plus in the UK

Current CCG, CSU and other NHS customers: All, through NHS shared business services and the NHS ESR; our enterprise performance management solutions are used by the Department of Health and our customer care systems are used by individual trusts; our virtual desktop systems are widely used by NHS Scotland and our services support the enterprise wide NHS SPINE platform

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: undisclosed

Main competitors: IBM and Microsoft

of the world, where the initial cost outlay may appear higher than conventional but the longer term cost and process efficiencies are significant.

7. How do you see the CS market evolving?

The NHS strategy is to evolve the CSU model, with mergers and private sector partnerships creating a more dynamic business model, as we've seen work successfully in other industries in which we operate.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

We would be very interested in partnering and our contribution could flex as appropriate.

Our current NHS customers span the breadth of the organisation as we offer both scalable enterprise solutions and niche capabilities. As examples our ERP and HR systems are widely used across the NHS, whilst our core technology underpins the majority of organisations. Our enterprise performance management solutions are used by the DOH and our customer care systems used by individual trusts. Our virtual desktop systems are widely used by NHS Scotland and our services support the enterprise wide NHS SPINE platform.

Biography

How does your career so far help you in working with the NHS?

In a career spanning over 20 years with two major, global corporations I have extensive experience of working in many major industries. The use of self-service as a competitive advantage in the finance industry and the customer centric models developed for retail are just two business models with applicability to the NHS' future challenges. I have been in my current role as head of healthcare for the past 18 months and previously I was the head of global accounts in Oracle UK.



What attracted you to working in this area?

As I mentioned in my previous answer the opportunity to bring some new ideas from other sectors to benefit the changing focus in the NHS is an exciting prospect and working in such a dynamic and complex industry is a welcome challenge.

What do you enjoy doing outside of work?

I enjoy many sports including diving, golf and hill walking. An extra benefit is that we do these activities as a family.

PA

Independent Sector Provider

Partner: Peter Bull

1. What CSSs will you provide over the next 12 months?

We have worked predominantly with commissioning support units (CSUs) in the delivery of value-add services to provide consultancy services. We are really clear that PA's strategy is not, as it stands today or in the near future, to do managed services type work such as the transactional elements of HR, IT etc. Our key offerings include organisational design and development, process, strategy, market and customer analytics. In the area of organisational development (OD), we help determine the right structure, helping CSUs think about roles and responsibilities capabilities and developing the relevant training to equip staff with the required skills. Around process, we have helped one of the CSUs in the northwest think about the right target operating model and how the processes fit into that. In strategy market, we helped CSUs think about both their current market and future market and the services they could potentially supply. So some of the more outwardly looking CSUs did think about whether they could provide, for example, IT services to other parts of the health system. Another service for CSUs is helping with pre and post merger integration, which may result from consolidation of CSUs. We have also done pockets of work for some of the clinical commissioning groups (CCGs) in London indirectly, through reconfiguration programmes such as Shaping a Healthier Future.

2. How is your business structured?

PA Consulting Group specialises in management consulting, technology and

innovation with clients in both the private and public sector.

Health is one of PA's major focus sectors. It is an area where we are strong both in numbers and quality, and in the offers that we go to market with. It is basically a matrix model, and the health teams will reach out to specialist practices as and when it is needed. Skills transfer across those teams and being able to draw on the specialisms and cross industry experience really give it strength as well as provide a fresh perspective.

3. What is different about your organisation, and why should commissioning organisations come to you?

I think in health we are experts in a number of areas including reconfiguration and transformation, particularly in project management, stakeholder management and the content aspects. We are also experts in terms of commissioning as well having worked in that CCG and CSU environment for a while. We are also strong in business intelligence (BI) on both the advisory side, and now, increasingly as a provider of business intelligence services such as medicines optimisation. We have worked with NHS England to develop a business intelligence (BI) platform and a BI front-end called the integrated intelligence tool, which provides access to a number of different data sources and around 100 key performance indicators (KPIs) within the system. It is interactive, allowing you to play with the data, ask it further questions and drill down into more detail. Being able to bring to bear ideas, concepts and methodologies from our work

with different organisations and industries including telco, airlines and finances also provides a real differentiator. PA was perhaps one of the first consultancies to recognise the need to do that in the commissioning space, and in that vein, I have introduced some of the CSU colleagues to my clients in other industries, allowing them to get access to new ideas and concepts.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

Commissioners have a huge challenge ahead of them in terms of what is actually needed for their region, for the area, and how they should be working as part of that system to ensure that the providers' side is set up to provide the right number of sites and services. A second big challenge within the system is negotiating who pays for services, such as telehealth and telecare, given the costs that can be saved on the provider side. The third big issue that I have witnessed is very much around getting your hands on good reliable data and then the interpretation and use of that data. My experience of working in different industries such as the telecommunications industry and the airline industry, is that they are quite a long way ahead of the health sector in terms of the way they structure data and access it to get answers to make clear-cut investment choices. While solutions such as PA's work with NHS England will help in that respect, I can see that being a challenge for quite a long time to come.

5. What partnerships or planned partnerships do you have? Who does your network include?

We quite regularly partner with one or two other organisations where there is limited overlap between our specialities. We are also testing the market talking to different CSUs about different levels of partnering

6. What are the major challenges of working as a provider of CSSs?

I think an overarching answer is getting the balance right between the work we do with CSUs and not wanting to be left out of the

Facts and figures

Number of dedicated staff in the healthcare team: undisclosed

Current CCG customers: undisclosed

Current CSU and other NHS customers: undisclosed

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: see answer to question 1

Main competitors: undisclosed

market to provide services to CCGs directly if a clear market for that opens up. We work well with a lot of CSUs and we would not look to upset that relationship. That said we would consider each future opportunity with CCGs on its merits.

7. How do you see the CSS market evolving?

We expect there to be further consolidation in the market, however, there may well be a number of different models alongside the CSUs.. Some CCGs may get together and find a way of providing the services themselves. My own observation is that NHS England appear to have thought about different models and different ways in which other organisations could be encouraged to be part of the system which should help to bring the right level of expertise to the market. Within CSUs, there is a whole spectrum regarding what they can provide, with rapid acceleration in development of services occurring in some CSUs due to a degree of poaching of people from other organisations. On the whole this has been done very effectively, and it's been done because they recognise that by importing these skills, they can get themselves up the curve very rapidly.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

Yes, both of those things; both leading and/or partnering. We are very happy to do that.

Biography

How does your career so far help you in working with the NHS?

With 20 years of experience of working across four or five different industries including life sciences, telecommunications, media and financial services, I've been able to bring to bear ideas and concepts and methodologies from all of those different organisations and businesses to provide a real capability and differentiator.

What attracted you to working in this area?

Bringing new concepts and innovation to the commissioning space including BI and analytics, and customer and market analysis and strategy.

What do you enjoy doing outside of work?

I enjoy spending time with my family and running.

Primary Care Commissioning

Independent Sector Provider

Chief executive: Helen Northall

1. What CSSs will you provide over the next 12 months?

We provide clinical commissioning groups (CCGs) with support in a number of ways, the most important of which is to help them to map the needs of their local population against their evolving commissioning plans. We provide training and knowledge development for their teams to support patient and public engagement, procurement, provider management, needs assessment and reviews of existing services.

In all cases, our focus is on how these skills enable transformational change and deliver outcomes for patients rather than on transactional concerns about levels of provider activity. We will continue to run facilitated development sessions with CCGs to help them to engage their members (general practices) in the work of the CCG and access the clinical expertise needed to inform service improvement and redesign. We are supporting them to develop teams with the skills needed to execute commissioning strategy and to understand where resources need to be developed in house and where they may need to be bought in. Work in the next 12 months focuses on team development and supporting CCGs to acquire the skills to support them in the new roles, but in the medium term the focus of support will be on assisting CCGs to develop primary care and strategic commissioning with particular emphasis on patient and public participation in all stages of commissioning from needs assessment to procurement and

monitoring of services. We will also help to embed lean methods to make commissioning more responsive and efficient.

2. How is your business structured?

A not-for-profit social business with roots in the NHS, Primary Care Commissioning (PCC) is an independent provider of practical, expert support to commissioners and general practices.

For every area we have senior managers who oversee and work with whoever is commissioning the service from us to make sure we are clear on the delivery specifications, the timeline and desired outcomes. Then we have some more locally-based teams – the advisors – who do the work, pull in the expertise and actually manage the project day-to-day. So we have a level of skill and then, where necessary, we would bring experts in for a day. If, for example, we were working on PPI and we needed an expert to do a session on that or facilitate a large event with patients and the public, or indeed help a CCG to manage a negotiation, then we may put in a skilled associate in that area and the team would manage the work day-to-day overseen by a senior team member. Normally we have about five people who would be working and linked to any project but depending on the scale of the project sometimes it is a team of a lot more. We have got one project running at the moment where we have probably got a team of about 15 working on it.

Our project work is underpinned by

events, local workshops and a range of practical resources that enable us to transfer capability to the organisations we work with.

3. What is different about your organisation, and why should commissioning organisations come to you?

We are not-for-profit with a social mission to deliver benefit to the NHS. We are really keen to transfer capability and share learning, so that is agreed with the commissioner across the broader NHS so that we don't develop a capability that sits with us. We have also got a number of locally-based advisors, as well as access to specialist expertise, so we can tailor programmes locally and have the local link to CCGs. We also quite often have links with other local commissioning organisations; for example, we are working on the primary care assurance framework with NHS England area teams. This work also benefits CCGs who can use the same tools to support local primary care development. We can actually help manage those relationships because we have local people who understand local situations, and often know the people working on these challenges locally. Our team has considerable knowledge of health policy and expertise in primary care. For example, our chair Professor David Colin-Thomé is a former GP and national director of primary care at the Department of Health. Example:

We supported a CCG to review inherited enhanced services arrangements and plan new locally commissioned services. This included supporting the CCG to plan how certain services would be decommissioned from existing providers and commissioned in new settings within tight planning timescales.

We also helped the CCG identify appropriate arrangements for public health services inherited from the outgoing commissioner now within the remit of the local authority.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

They have just got so many challenges and I think it is about moving from transactional

Facts and figures

Number of dedicated staff in the healthcare team: 45

Current CCG, CSU and other customers: 45 CCGs, NHS England, Health Education England, local authorities and general practices

Percentage of income from NHS contracts: about 97%

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: support across the commissioning cycle, team development, facilitated development, bespoke support

Main competitors: other independent sector providers of commissioning support and consultancy-type services to healthcare

services to really being able to transform care and to be able to shift towards being much more of a preventative service. Obviously they still need to treat illness, but it's also important to get a little bit more ahead of the curve and reconfigure to get the service sustainable for the future. There are so many changes that need to be made from more integrated care, more personalised care, and starting to look at how the service can move the available extended hours and then obviously 24/7 service, and how that can be enhanced, perhaps, in primary care as well as on the acute side. I think that is really challenging.

Obviously the financial challenges are severe at the moment across the whole system. Unless action is taken now to start to look at how more capacity could be developed and how primary care providers, for example, could work together to deliver more services in the future, it is difficult to see how the necessary changes could be made to allow the things to add up in the future. It's also a matter of balancing increasing demand with reconfiguration and how you can develop the primary care and out-of-hospital sector to help to meet some of those challenges.

5. What partnerships or planned partnerships do you have? Who does your network include?

We do work with several organisations including large consultancies and some business intelligence organisations. We also have about 50 associate companies who are on our preferred supplier database who we would work with if we reach capacity in our team or if we need specialist expertise or support in a particular area.

6. What are the major challenges of working as a provider of CSSs?

I think the main challenges are actually helping the CCGs to realise and understand their responsibilities and that although CCGs may wish to commission work out, they are still ultimately responsible for delivery. Quite often, when we do get a specification to put a quote against a tender, we sometimes then

Biography

How does your career so far help you in working with the NHS?

I have been in this post since the organisation was developed just over five years ago. Before that I worked at a national level in healthcare improvement organisations, including the Modernisation Agency where the initial PCC team was formed. After the closure of the agency, I led the development of the work of the primary care commissioning team as a business in its own right.



What attracted you to working in this area?

I have worked in the health service for many years. I originally started off working in an acute trust as a medical scientist, and I became very interested in commissioning because I could really see the opportunity of commissioning to change services and provide better services for patients. So I worked in a number of commissioning organisations, but was driven to pursue the wider opportunity for support and development, spread of best practice and healthcare improvement.

What do you enjoy doing outside of work?

Horse riding.

need to put some caveats around it just to highlight the bigger picture that should be looked at: patient and public involvement, has an equality impact assessment been considered when there is a change of service, and just making sure that we are supporting the CCG to follow due process. I think the other area of challenge is helping CCGs to understand how to pick the most appropriate support. Often this will involve smaller organisations, which may offer better value for money or specialist skills and expertise that bigger companies may not possess.

7. How do you see the CSS market evolving?

I think it is quite interesting how it has evolved to date, particularly with the CSUs, because we have already started to see a decrease in numbers there. I think that we will probably continue to see a decrease and see CSUs working together more, and perhaps using networking and linking with smaller organisations to get the detailed expertise in some of the areas needed. Hopefully, as CCGs develop, they will also look to smaller independent sector, not-for-profit sector or

voluntary sector providers as well. They may also perhaps be more discerning and think about which areas are best done at scale, via CSUs who can perhaps bring a number of CCGs together to perhaps commission services from a large acute trust, and what may be better done at a local level with, perhaps, a smaller provider. So I think the market needs to mature and CCGs need to look at what is done best at what scale.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

We would be really happy to partner for such a framework. Potentially we could also lead a framework, but we are more of a niche provider and would probably be better as a partner.

Provex Solutions

Independent Sector Provider

Director: Peter Maddock

1. What CSSs will you provide over the next 12 months?

The work we have carried out so far includes assistance with business cases and models, commissioning strategy, coaching and mentoring, communications and consultation processes and service reviews. For example, we have worked with the Arden commissioning support unit (CSU) to support some of its authorisation processes and marketing strategies, and helped it to carry out a review of the quality, innovation, productivity and prevention (QIPP) process for all of its customers. We have also supported the CSUs with their financial staffing resources by securing people who can work with them to make sure they have enough financial capacity as well as to help them deliver tasks as part of their ongoing work. With regards to mentoring and coaching, CSUs have asked us to support their new teams in understanding their business requirements and developing the skill sets needed in their new roles, for which

we can offer a tailored programme. They may also need help with role adjustment as CSUs are now in a position where they need to pay careful attention to the specifications provided by clinical commissioning groups (CCGs) who are now the customers. We have also supported CCGs, partly through the CSU and partly by direct commissions, including helping with organisational development, construction of commissioning strategies and developing the required specifications to buy a service.

2. How is your business structured?

The company is a collaboration of five established organisations, each with proven track records and unrivalled experience of working as part of the NHS family.

Our business is linked to another organisation called Provex Consulting, so they are two organisations that work very closely together. I am a director of Provex Solutions, and some of the directors at Provex Solutions are also directors at Provex Consulting. So this

is a portfolio organisation. The organisation itself comprises a number of individuals who have had senior experience in the NHS, at chief executive or director level, but also those who work in general practice and urgent care, communications and chartered accountancy. Around this core of personnel, there are a cluster of people and organisations we can call on to provide individual or extended support as needed, providing flexibility. So depending on the service that is required, we will assemble the relevant expertise and provide a tailored solution to the individual organisation.

3. What is different about your organisation, and why should commissioning organisations come to you?

Having a very diverse team of individuals who have had senior experience in the NHS at chief executive or director level, clinical professionals and Coventry University who has a track record in organisational development as one of our key partners, we have a wide perspective of the NHS and a fresh perspective on organisational development challenges. We also have a portfolio of very experienced project managers who can go in and help people deliver projects to tight time scales. We also have considerable experience of service reviews including making sure they have been carried out effectively and that care pathways can be changed. For example, we looked at a whole health system and involved local hospitals and other provider services commissioners to see whether a review of capacity and service delivery was necessary. We have also carried out work to help people identify new areas they may want to look at for QIPP and evaluated current plans. Another area of expertise is communications and consultation processes, as one of our partner organisation carries out a lot of work for local government, health and commercial companies around marketing plans and communication processes, which we can channel into marketing and communication of service changes for CCGs. This includes developing plans to communicate changes to the stakeholders, the public and patient groups as well as understand their thoughts, which can be a difficult process to manage. We also

Facts and figures

Number of dedicated staff in the healthcare team: 12 plus

Current CCG, CSU and other NHS customers: NHS Birmingham CrossCity CCG, NHS Coventry and Rugby CCG, NHS South Warwickshire CCG; NHS Arden CSU; Birmingham Children's Hospital NHS Foundation Trust, Birmingham Community Health Care NHS Trust, Coventry and Warwickshire Partnership NHS Trust, Heart of England NHS Foundation Trust, Liverpool Clinical Laboratories, NHS Elect, NHS England, Sandwell and West Birmingham Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, Shropshire Community Health NHS Trust, The Royal Wolverhampton Hospitals NHS Trust, University Hospitals Coventry and Warwickshire NHS Trust, Walsall Healthcare NHS Trust, West Midlands Ambulance Service NHS Foundation Trust, Worcestershire Acute Hospitals NHS Trust

Percentage of income from NHS contracts: 100%

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: 20%

Service coverage/types of service provided: Business planning - business cases, integrated business plan, local health economy system plans, mergers & acquisitions, procurement and training. Commissioning support - financial and strategic planning, business planning, personal finance planning, organisational development, primary care management, communications and engagement, clinical and corporate governance, project & programme management, information analysis & QIPP review

Main competitors: At the moment, the big consultancy firms as they can offer a national footprint for all of these services and are known players with a known track record across the whole of the UK

have a director who is a GP who has worked in urgent care and can link to other doctors when developing alternative models of care. For example, we have already been engaged to look at reviews of emergency care services including what is happening in primary care to see what could be changed to improve services.

4. What challenges do you feel NHS commissioners face? How do you believe CSSs can add value for them?

CCGs as membership organisations are commissioners who have to manage potential conflicts of interest, and a key challenge will be understanding their new roles, developing their members and making the necessary changes to deliver better patient care. The members as doctors in their surgeries, will have a lot of very good ideas in terms of what needs to change, but will not have a lot of experience in how to make those changes work. Secondly, part of the adjustment to their new role is getting used to a relationship with CSUs as providers of services when historically they may have been colleagues that they worked alongside within primary care trusts. This includes an understanding that as a customer for a substantial investment, CCGs will need to be very precise on what they want, how they want it to be delivered, and how they are going to performance manage that.

5. What partnerships or planned partnerships do you have? Who does your network include?

Our key partner organisation is Provex Consulting who specialise in business case development and have done a lot of work in the secondary care sector. We also link to Coventry University to provide tailored organisational development support services. Two of our core portfolio companies are a marketing company, called Parenthesis and a chartered accounting company called Fox Evans. There are also a range of individuals who are independent consultants with senior NHS experience who can be called on,

6. What are the major challenges of working as a provider of CSSs?

There is a cultural adjustment to be made for

Biography

How does your career so far help you in working with the NHS?

I spent most of my working career in the NHS. I joined the NHS at the age of 22 in a finance discipline, and worked through the NHS undertaking roles such as commissioning director, hospital director, primary care group (PCG) and primary care trust, chief executive. I have therefore spent a lot of time on both provision and commissioning at senior level, helping me to understand the way the NHS works, and also the political environment that we have to work within, and how important communications and patient involvement are in the whole process. Prior to my current role which I started in 2012, I had my own independent consultancy, which corralled a lot of tailored support into commissioning and hospital organisations.



What attracted you to working in this area?

That is my specialist area, really as my whole career for the last 20 years has been in commissioning and provider management. As a manager, before I became chief executive, I was both commissioning director and a hospital director.

What do you enjoy doing outside of work?

I have four young grandchildren who keep me very occupied and entertained. I also like gardening and sport in general.

CSS organisations where they now need to view CCGs more clearly as customers.

What appears to often happen at the moment, is that CCGs feel that CSUs are not delivering what they want whereas CSUs feel that CCGs are not being precise enough about their needs, where the truth probably lies somewhere in between.

The Provex solutions approach to support will be to obtain clarity on our customers requirements, propose detailed work plans and deliver to defined and agreed timescales.

One of the main challenges for ourselves is finding the way into the marketplace and finding the way that we can actually engage with the CCGs. The big consultancies are there on framework agreements and are known throughout the NHS.

Our customer base is based on our past work projects and our reputation for delivery. So it is for us to be able to get into the marketplace and actually get a foothold in the areas where we are less well known – it is a challenge for us but one we relish.

7. How do you see the CSS market evolving?

Over time, I think there will be a smaller number of larger CSS organisations which are more focused in terms of a core offering. There will be a tendency towards a view that CCGs will require a lower level of core services, but will require more on a bespoke or project basis. In this respect, the CSS market will have to respond flexibly, and may have to bid for more work rather than it going automatically to local CSUs as part of a core contract. So I think there will be less buying up front, and more, 'We will buy but we will buy on a project basis'. I think that will come reasonably quickly. There will also be opportunities for more work to be carried on behalf of local health economies to include all partner organisations.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

Yes, we are quite open to the idea of both supporting and possibly leading.



Independent Sector Provider

Director in the health industries practice: Rob Yearsley

1. What CSSs will you provide over the next 12 months?

With a growing and ageing population, the NHS is facing a funding gap of £34-£54 billion over the next 10 years. We believe closing this gap can only be achieved through a transformational resetting of the health and social care economy. We are working alongside commissioning support units (CSUs), clinical commissioning groups (CCGs) and local authorities across local health economies to help make these transformational changes at pace with a focus on patient-centred outcome-based commissioning. We are helping commissioners, clinicians and other stakeholders redesign 24/7 care, that is increasingly delivered closer to home through innovative services, enabled by adopting a digital agenda and the sharing of data. We support the full commissioning cycle, including procurement of contracts, monitoring of contract performance, data capture management and integration, and business intelligence and analytics. We are moving towards a consulting model focused on the delivery of outcomes and value, so that our fees tie in with the risks and benefits derived from delivery. For example, we are working with a CSU and a number of CCGs around outcome-based contracts where the CCGs are managing a cohort of citizens

and sharing the financial saving from good health outcomes rather than payment by activity.

2. How is your business structured?

PwC provides assurance, tax, deals and consultancy services to the public sector, including a specialist practice in healthcare. Our dedicated cross discipline regional teams have in-depth experience and insights into the organisational challenges, commissioning opportunities and health economy dynamics that lie ahead for CSUs and CCGs.

Our health practice brings together experts from across the firm, including assurance, tax, deals and consulting. We have a number of clinicians in the practice who have worked in both commissioning and the provision of services ensuring pragmatism in our recommendations. In the commissioning support space, we typically draw on people from tax, consulting, our actuarial and economics teams, to pull the right skills together and bring the required rigour and governance to solutions.

3. What is different about your organisation, and why should commissioning organisations come to you?

We recognise the scale of the challenge the

NHS faces and are keen to work alongside commissioners to help them address these challenges. Successful delivery at pace is important to our clients so we have created what we believe are some critical capabilities commissioners will be looking for in a partner.

Alongside our health experts, we have a strong health economics practice, enabling us to support evidence based business cases from a statistically sound economic perspective. We bring in actuarial skills alongside traditional analytics, including forensic analysis, to provide greater insight and better help healthcare organisations understand risks. We are focused on understanding the outcomes that our clients will use to measure success and support organisations in the achievement of these outcomes. For example, during CCG authorisation we supported NHS England in defining the desired outcomes of the process and helped implement the infrastructure to take all 212 CCG organisations through a robust, auditable process in 6-8 months.

We have a strong network across the whole landscape of stakeholders within health and social care. We are working with some financially challenged health economies and our ability to engage with and help commissioners navigate between NHS England, the Trust Development Authority (TDA), the Department of Health, regulators, local providers and the CCGs is of great value to our clients.

4. What challenges do you feel NHS commissioners face? How do you believe commissioning support can add value for them?

One of the real challenges that commissioners face is creating sustainable and flourishing health economies and delivering many of their innovative services at scale. A fundamental challenge within that is managing the clinical leadership while engaging stakeholders around the needs of the patient, without the short-term organisational impact becoming a barrier to producing a solution that everyone can buy into. A further challenge is responding to the increasing demands of patients and trying to encourage people to take more ownership for their own health and wellbeing.

Facts and figures

Number of dedicated staff in the healthcare team: About 250

Current CCG, CSU and other customers: Over the last two years we have worked with more than 100 CCGs; we work across the health sector with CSUs, NHS foundation trusts and local authorities as well as national organisations including Monitor, the CQC and NHS England

Percentage of income from NHS contracts: undisclosed

In percentage terms, approximate growth in 2013/14 healthcare revenue attributable to the latest NHS structural reforms: undisclosed

Service coverage/types of service provided: organisational transformation, workforce strategy and restructuring, integrated care, health and data analytics, mergers and acquisition support, patient relationship management, project and programme management and finance, turnaround services, health economics and regulation, IM&T, supply chain management (procurement and contract management) and post merger integration

Main competitors: undisclosed

We see the CSUs as being an integral part of CCGs and being the delivery vehicle that helps CCGs achieve these objectives.

5. What partnerships or planned partnerships do you have? Who does your network include?

We work in alliance with a wide range of organisations that bring breadth and depth to our expertise. Current alliances, for example, include Beacon UK, COBIC, Common Purpose, Cumberlege Eden & Partners, Practiv, The King's Fund and Wragge & Co.

6. What are the major challenges of working as a provider of CSSs?

There is a real challenge for providers of CSSs to deliver their services effectively within the allocated cost envelope, while also investing and freeing up the capacity to start supporting the transformational aspirations of CCGs. The need for CSUs to respond to the local variation in requirements of CCGs, while maintaining efficient service delivery, is a significant additional challenge for CSUs. The key challenge for the independent sector is to articulate the value that they can bring and also deliver that value in the existing cost envelope.

7. How do you see the CSS market evolving?

We believe the scope of CSU services is unsustainable at their current scale and their development is constrained by limited investment funds being spread across their broad portfolio of transactional and transformational services. As CCGs get to grips with their health economies and the size of the challenge they face there will be greater demand for the more transformational services. Given the uncertainty of their future, CSUs may develop in two ways - consolidating even further to a position where they still offer a broad service portfolio but are at scale, robust, stand-alone organisations or they may remain more numerate but focus on delivering a few innovative and entrepreneurial services, where they can articulate clearly the value they can offer the NHS and potentially to other markets as well. All of that will probably

Biography

How does your career so far help you in working with the NHS?

Ten years ago I started to get involved with the NHS, helping to establish collaborative procurement across health economies, including the set-up of collaborative procurement hubs, helping NHS Trusts and primary care trusts to procure products and services at a lower cost. That naturally led to me helping commissioners understand how collaboration across the broader commissioning cycle could deliver better outcomes for patients and ultimately how CSUs do this effectively on behalf of the CCGs. I've also spent a long time looking at effective negotiation and contract management in the NHS to realise the savings offered by good procurement practices. I joined PwC a year ago; prior to that I worked for over 20 years leading the delivery of complex projects in the media, automotive, aerospace, pharmaceutical and healthcare industries.



What attracted you to working in this area?

I think as an industry, health is probably one of the most complex in terms of the supply chain and how the services are delivered. But when you think about its fundamental purpose, which is to improve quality of life for patients, it is definitely one of the most rewarding. Also, from a personal perspective, my son was quite ill when he was born. The NHS was instrumental in his recovery and it is about giving something back, recognising the fantastic service they provided. There is an affinity there with the service and wanting to see it succeed, deliver the best healthcare it can and helping sustain the principles of the NHS.

What do you enjoy doing outside of work?

Outside of work I enjoy the open air with my family, particularly sailing on a local lake where I compete with my sons and help others learn to sail.

involve consolidation of CSUs, through formal mergers or informal alliances.

8. CCGs have shown an interest in procuring CSSs via prime or alliance provider models – would you be interested in this?

We are investigating new business models enabling us to partner with organisations to either be a lead provider on the framework or a significant partner alongside a lead provider to support commissioners. We have set up similar partnerships to deliver back and middle office services to the new Academy schools.

