Grant Thornton

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How CCGs can collaborate successfully

Spring 2017

Contents

Executive summary

"We would like to see more collaboration. There are things we are desperate to learn about. It's one NHS at the end of the day … It's about achieving collaboration and using it as leverage with our providers. Unless we're in it together we won't succeed; it's about more than the commissioner/provider split."

A round table participant

Key findings from the round table

This is a pivotal moment for the future of healthcare provision. As pressure continues to mount on budgets, commissioners must adapt in order to ensure their long-term success. The ability to work collaboratively with sector partners will allow commissioners to develop resilience through delivery at scale. Innovative working practices will also encourage administrative as well as financial efficiency, freeing up senior leadership to work at a more strategic level. This will also aid the joint redesign and restructuring of services to better meet patients' needs. There are many models of collaboration available and it is certainly the case that one size will not fit all environments.

Good governance is also vital here. Above all else, CCGs must not lose sight of their primary obligations to their responsible populations. The drive for efficiency and resilience must not come at the cost of fulfilment of statutory responsibilities or the failure to stay within the boundaries of their legislative powers. CCGs therefore need to consider carefully the structures to be created and then make this clear in their constitutions.

However, as one roundtable participant commented, the NHS cannot continue "constantly reinventing the wheel time and time again". Lasting cultural change must be effected to ensure that we see a genuinely sustainable benefit. Therefore organisations need to give priority to nurturing a positive and shared culture both within and between organisations and then ensure that this is successfully preserved.

Furthermore, CCGs must take the spirit of collaboration beyond the boundaries of primary healthcare and look to work with providers and other stakeholders to ensure their combined commissioning voice contributes to joined-up working towards improved outcomes as 'one NHS'.

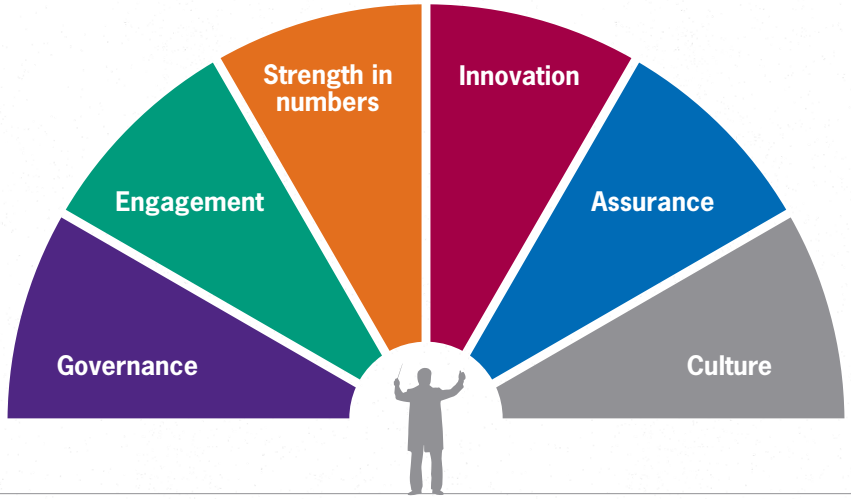
The role of clinicians and particularly GPs on CCG boards was felt to be key in providing the leadership required to drive changes. The need for more support from CSUs to facilitate the commissioning process was also identified.

Despite the inherent obstacles, our participants remained broadly positive about their journey into the brave new world of collaboration. There are admittedly risks. However, it was felt that these could be overcome and greater collaboration was a positive step resolving the patient-care and financial issues impacting on the NHS.

What is happening now?

- Motivated by financial pressures, the opportunity to achieve economies of scale, the need to improve the resilience of their organisations and their wish to present a single commissioning voice to providers, CCGs across the Midlands and beyond are increasingly exploring new ways to work collaboratively
- Currently, the most common method of collaborating is the introduction of a shared accountable officer (SAO) across a group of partnering CCGs. Other practises include shared back office teams and the increased use of 'committees in common', with some practitioners seeing the advent of formal mergers as an 'end game'
- Increased collaboration among CCGs is now seen as a stepping stone towards the eventual successful establishment of multispecialty community providers (MCPs) combining provision of primary, secondary and acute care from a single source

Recommendations to support collaboration



Governance

CCGs need to commit to setting up and maintaining good governance structures in any move towards collaborative working. CCGs must ensure that they don't lose sight of their individual responsibilities and compromise their obligations to their local populations in the move towards collaboration. Individual CCG arrangements for obtaining assurance over decisions taken at the group level is paramount to the future success of collaborative working. Be clear on the legislative responsibilities around the ability to delegate in a collaborative arrangement. Have strategies in place to ensure where arrangements could draw decision-making power away from accountable individuals while leaving them responsible for the actions of the CCG.

Engagement

CCGs must ensure that sufficient 'buy in' is achieved to effect the required cultural change and that key stakeholders are not left behind. The pace of change is vital and continued support of lay members and GPs will be crucial for future success. GPs in particular value their independence and may resist any perceived loss of 'local control' in a future merger or collaborative arrangement.

Strength in numbers

CCGs should look to face the market jointly and ensure a single, coherent commissioning voice is heard. Furthermore, they should seek to remove the artificial 'Berlin walls' of the commissioner/provider split to deliver positive outcomes across local health economies as 'One NHS'.

Innovation

CCGs need to explore alternative delivery models and greater use of technology for services. Practitioners should seek to emulate and share examples of best practice from across the sector in order to further develop resilience and efficiency.

Assurance

CCGs and their partners need to prepare robust business plans that will support the changes being proposed. Getting the finances right is essential to ensure any newly merged CCG or MCP starts off on a sound basis. Given the significance of many proposals these should be subject to independent validation.

Culture

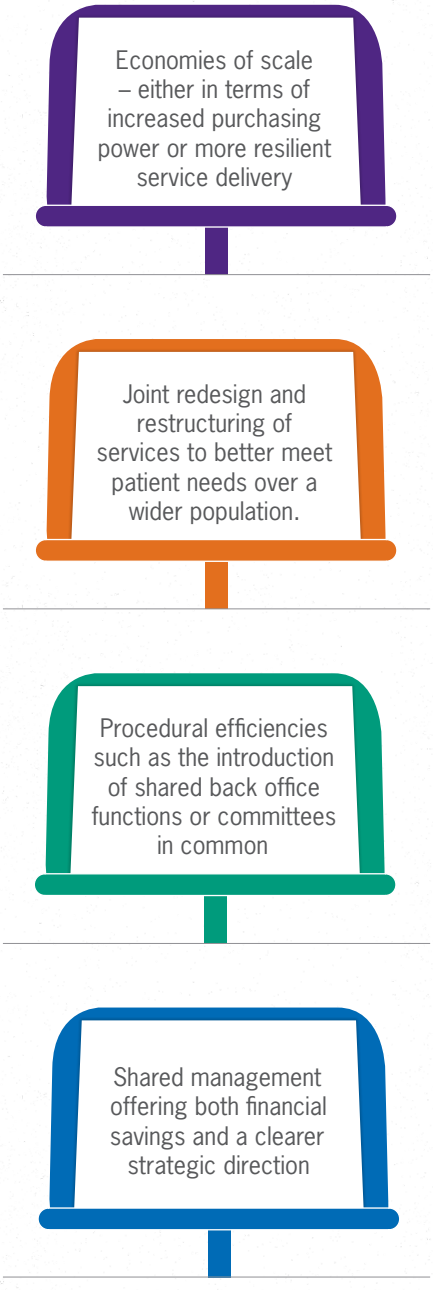
CCGs should nurture a collaborative culture with common values and common purpose, both within the organisation and between organisations. Once embedded the culture needs to be maintained by demonstrating high behavioural and accountability standards.

Introduction

In these austere times, the concept of collaboration within public services is undergoing a revolution. From the devolution of spending powers, to a collective of local authorities and health bodies in Manchester, to shared back office functions, change is happening across the country. Organisations are increasingly seeing the opportunity to build resilience and efficiency through delivery of services at scale as the antidote to the twin pressures of increasing demand and insufficient resources.

The drivers of the move towards collaborative working are legion. A perfect storm created by central government focusing keenly on protecting the public purse and delivering best value for taxpayers, the high expectations of a public accustomed to excellence in the services it receives, and an increasing level of demand driven by an aging population have all contributed to a movement towards greater collaboration. In addition to these external motivations, there is a recognition from within the public sector itself that a joined-up, multi-agency approach can provide a boost to quality, as well as helping to manage economy. There is a growing view that collaboration offers public services the opportunity to redesign and introduce alternative delivery of services rather than simply cutting services.

Broadly speaking, the 'collaboration dividend' can be measured in terms of efficiencies, both financial and operational, achieved across four main areas:



From the introduction of innovations such as the use of Commissioning Support Units, the NHS itself is already using some of these ideas with varying degrees of success.

Currently, the most common method adopted is the introduction of a Shared Accountable Officer (SAO) across a group of partner CCGs. Other options include shared back office teams and the increased use of 'committees in common', with some practitioners seeing the advent of formal mergers as an 'end game'.

Increased collaboration among CCGs is now seen as a stepping stone towards the eventual successful establishment of multispecialty community providers (MCPs) combining provision of primary, secondary and acute care from a single source.

NHS England guidance

NHS England published guidance in early November on CCG mergers which has six criteria. This includes a statement that the new CCG will "provide a more logical footprint for delivery of the local STPs" and have the "right critical mass to discharge [a] more strategic commissioning function" given the "likely" emergence of new provider structures accountable for the health of populations. They must also save a fifth of management costs. (See table on page 5.)

The November guidance indicates clearly that some CCGs will now be allowed to join together. Only one CCG merger has so far been allowed since they were created in 2013 – Gateshead, Newcastle North and East, and Newcastle West CCGs in April 2014. Recently NHS England leaders announced that more mergers would be permitted and CCGs in several areas including Manchester, Birmingham and Buckinghamshire, have signalled their aspiration to do this.

The guidance also revises how NHS England will consider CCG applications for changes to their constitution. This will include the "fit with" STPs, as well as their performance on the CCG assessment framework.

It is likely in the short-term that there will be substantially more instances of CCGs moving to shared leadership, management and governance, rather than merging. Whatever the chosen format there is a reality that the commissioning sector is in for a period of substantial change.

NHS England guidance on CCG mergers, November 2016

The six new factors to be considered before mergers:

1 Strategic purpose	To provide a more logical footprint for delivery of the local STP
2 Prior progress	The relevant CCGs must have already demonstrated progress in systematically implementing shared functions; and there is evidence of a willingness to work together. Ideally mergers should be a natural next step rather than a major organisational upheaval. Where no formal joint working is already in place, the CCGs should demonstrate how they will implement the change simply and quickly, without the merger distracting both organisations from the more important task of implementing the Five Year Forward View, achieving financial balance and delivering core performance standards
3 Leadership support	The merger proposal enjoys the support of the STP leadership; the support of constituent CCG governing bodies; or it forms a necessary part of an agreed turnaround plan for a CCG under directions
4 Future-proofed	The merger proposal provides the right footprint for oversight of likely local multispecialty community providers and primary and acute care systems and should have the right critical mass to discharge the new, more strategic commissioning function
5 Ability to engage with local communities	We would want assurance that the move to a larger geographical footprint is not at the expense the new CCG's ability to engage with GPs and local communities at locality level
6 Optimising the use of administrative resources	The merger should show how 20 percent in ongoing running costs will be released to supporting local system transformation, including how the changes are commissioned

Pre-existing factors to be considered:

- **Coterminosity with local authorities**: there is a presumption in favour of CCGs being coterminous with one or more upper-tier or unitary local authorities. If it is not, and a local authority objects, NHS England will consider the views of both the local authority and of the proposed CCG
- **Clinically led**: the new CCG should demonstrate that it will remain a clinically-led organisation, and that members of the new CCG will participate in decision making in the new CCG
- **Financial management**: NHS England will consider whether the new CCG will have financial arrangements and controls for proper stewardship and accountability for public funds
- **Arrangements with other CCGs**: the new CCG will have appropriate arrangements with others, for example lead commissioning arrangements

Through a summary of discussions between our roundtable participants, along with a review of case studies and intelligence from the healthcare sector and beyond, this paper looks at the case for collaboration within the NHS. It also outlines the options available and the obstacles which must be overcome in order to effect meaningful cultural change.

Collaboration and the NHS

Round table summary

Participants in a previous roundtable discussion[1] on the future of primary care had told us that "an alternative model of healthcare is inevitable". To that end, within primary healthcare, we are seeing increasing levels of collaborative working, including the creation of larger 'super practices' to take advantage of superior purchasing power and offer greater stability to practitioners as well as consideration of single patient platforms. There are also collaborations between primary and acute providers which aim to increase efficiency and reduce duplication of effort by providing a single first diagnostic point of contact for service users.

As the ultimate controllers of local healthcare budgets, CCGs clearly have a role to play here. The case studies from our previous round table on the future of primary care provide encouraging signs that innovative redesign in primary healthcare services can have a real positive impact on the number of unnecessary hospital admissions of A&E visits in an area.

The prevailing sentiment from the round table was that the focus on the internal market has led to a loss of focus on the strategic purpose of healthcare bodies. Instead, their energy is focused on the operational minutiae of dealing with tasks such as contract management. As one participant put it: "can't we just forget all that procurement stuff and design a functioning local system? What matters is that we get outcomes which make sense to our stakeholders … who's going to take us to task if we achieve that by increased collaboration?"

"The only way anything is going to happen is if we work together; over the past few years the commissioner/provider split has put up Berlin walls."

Round table participant

This view ties in with the overall feelings of our roundtable participants: that CCGs and other organisations need to be free from the narrow definitions of the commissioner/provider split to pursue the best outcomes at the local level for healthcare provision.

Participants also felt that CCGs, in common with the health economy as a whole, have lost the capacity to "hold the system to account". Despite this concern, many of the participants were broadly positive about the NHS's Sustainability and Transformation Plan (STP) and its system of 'footprints' for collaboration among commissioners, providers and healthcare practitioners. Participants commented that the STP would enable CCGs to "manage our partners".

While STPs were viewed as a step forward, there was also a sense that these reforms did not go far enough. For example, concern was raised about the lack of cross-border STPs and joint planning between English, Welsh and Scottish authorities. Some commissioners in English border counties felt that patient flows between themselves, Wales and Scotland hadn't been taken into account. Others reported that the footprint concept, while a positive development, had an arbitrary feel in some areas, with significant patient and cash flows between English regions being overlooked.

Comments were also made that areas with differing demographic profiles had been paired together, making the redesign of services more difficult. Participants felt that geographical regions with contrasting rural and urban areas were particularly exposed to this problem, as were city regions with contrasting areas of prosperity and deprivation.

Ultimately, our participants felt that there was a "need to demonstrate that the money going in has an equal output in each area". Without this balance there was a concern that this could marginalise some partners who would gain little from collaborating.

[1] 'Primary concern: Shaping the future direction of primary care', Grant Thornton UK LLP, 2016

A culture clash between areas drawn together under an STP footprint was also seen as a potential hindrance, with one participant commenting of their organisation's experience: *"We haven't got a commonality of approach and we never will due to our diversity of populations and need for separate, place-based approaches."*

Encouraging collaboration was seen as a positive step and all of the participants recognised the need for greater joint working. A number of practical concerns were discussed. It was felt that beyond the high level there were few details of how the mechanics of the STP were to work. Some participants were also concerned that joint working arrangements may expose CCGs to the risk of stepping outside of their legislated powers:

"One of the issues we're still working with is what to do with primary care … can you delegate and then re-delegate?"

There was an overriding sense that the responsibility of making a success of all of this had been left on the shoulders of the commissioners themselves, with little concrete advice from NHS England. In particular, more clarity is needed on what may be considered acceptable from a legislative standpoint. (See page 10 for governance and legal issues.)

The consensus on this issue from within our roundtable was that CCGs would need to be innovative in how they retained engagement from the original governing bodies.

Another key concern expressed by our participants was that the local flavour of CCGs would be sacrificed to achieve the efficiencies and resilience afforded by joint working arrangements. Many participants were quick to compare CCGs with their predecessors, primary care trusts (PCTs), with several remarking that the key difference between the two types of organisations is the influence of local GPs:

"We used to have one PCT across the county but the GPs were most insistent that they wanted to work in smaller localities'."

The sense that the strength of CCGs lay in their clinical leadership and community connections quickly emerged, with many participants feeling that GPs themselves would be critical in ensuring the public buy in to the proposed changes:

"CCGs need to use their clinical leaders in exacting these changes; they need to be the face of selling what the CCGs do."

Therefore, while support from NHS England for collaborative working was seen as encouraging, participants also felt that there was a lack of attention to detail from the regulator:

"CCGs are a different beast to what went before … GPs feel 'we own a piece of this'. They are independent and that is not appreciated by 'our masters'."

Others spoke of the concern some GPs in their region had that local 'pockets of deprivation' would be overlooked by a larger regional organisation:

"NHSE doesn't always seem to realise that they are dealing with two separate statutory bodies rather than a single geographical area."

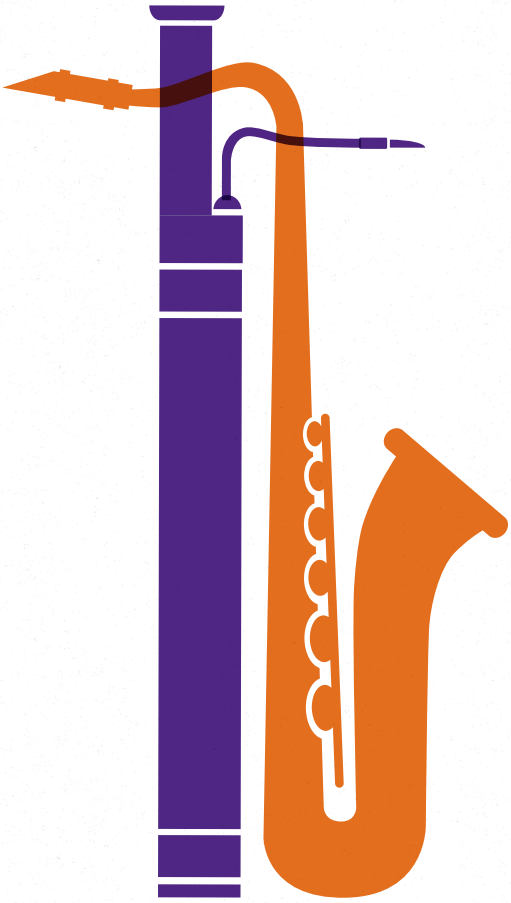
Unsurprisingly, therefore, our participants felt that managing the pace of change to ensure that GPs remained on board was of utmost importance. One participant commented, *"keeping that passion at the heart of it is what CCGs have done differently … what we can't do is throw the baby out with the bathwater by leaving our members behind."* Participants were confident that if they were given sufficient time that they could manage the change process well. They also appeared to feel that this was perhaps not well understood by regulators.

One participant commented that three CCGs in Birmingham were looking to complete a full merger within 18 months. The time frame was felt to be realistic both to allow time to set up appropriate governance and administrative arrangements and to embed the kind of cultural change required to make that kind of transition.

Despite the concerns expressed above, several of our participants reported positive experiences from collaborations within their geographical areas, as documented in the case studies on page 9. The most frequently referred-to innovation was the use of committees in common which were viewed as a way to increase efficiency and communication across the region without compromising standards of governance. Another positive here was the belief that GPs did not view these as "scary", due in part to the absence of the word 'joint' from their title. These committees were viewed as a strong way to promote the benefits of collaborative working without taking too great a step forward.

Other administrative benefits have also been discovered. Participants from the East Midlands discussed the move towards insourcing the commissioning of support services via a proposed 'matrix' structure (see Derbyshire case study). A prevailing sentiment was that some CSUs had failed in their aim to facilitate the commissioning process. It was felt that organisations could benefit by coming up with innovative ways to exploit and share the expertise present within the CCGs themselves.

Despite the inherent obstacles, our participants remained broadly positive about their journey into the brave new world of collaboration. There are certainly risks such as maintaining a local voice, appropriate governance in the new structures and avoiding creating new (admittedly larger) silos that don't work outside of their borders. However, it was felt that these could be overcome.



Despite the concerns expressed above, several of our participants reported positive experiences from collaborations within their geographical areas, as documented in the case studies included in this section.

CCG collaboration in the Midlands

Case studies

Birmingham and Solihull

The three CCGs in Birmingham and Solihull are proposing to merge in 2018. They have already set up a health commissioning board (joint committee) which meets in public. The three CCG chairs, accountable officers and a mixture of clinicians, senior executives and lay advisers from each of the organisations sit on this group. Where permitted and wherever possible, joint decisions are made here. However a certain flexibility is required as some governance functions are retained by individual CCGs. The health commissioning board has delegated authority from each CCG governing body to make decisions on their behalf, but remains accountable to the three governing bodies.

Beneath the governing bodies and health commissioning board, a number of existing committees have already began to evolve into either joint committees or 'committees in common' depending on their function and the constitutional requirements of each CCG.

The CCGs are working towards a single executive team as part of the merger process.

Worcestershire

The three CCGs now share a joint management team and currently have many committees in common including audit and governance, remuneration, quality and performance. The chairing of the meetings is rotated between the individual CCG committee chairs. There is not yet a formal merger plan. The CCGs are currently drafting an operating model and have already standardised policies in many areas such as an information governance and assurance framework. Since their inception, Redditch and Bromsgrove CCG and Wyre Forest CCG have shared a management team and utilised a series of committees in common.

Derbyshire

Joint management teams are not yet in place. However there is a '4 + 4' meeting which brings together the four AOs and four chairs enabling some decisions to be taken on a Derbyshire-wide basis and fed back to the individual CCGs. A collaborative 'engine room' with representatives of all stakeholders has been set up to deal with the implications of the STP. There is a risk-sharing arrangement in place between CCGs.

Nottinghamshire

Five rural CCGs work closely together and share a looser affiliation with the urban Nottingham City CCG. Collaboration within the groups tends to focus on 'global' issues such as commissioning and some policies are already joint (such as information governance). More specific issues, such as HR, are still dealt with at the individual body level. Currently, the CCGs employ staff separately and recharge them.

The CCGs are looking to form a committee in common for commissioning and also at how they can work more collaboratively within the shared arrangements with Nottingham City CCG. As a result of having two major acute trusts, commissioning arrangements are moving more towards a mid-Nottinghamshire and south Nottinghamshire and Nottingham arrangement.

Staffordshire

The six CCGs in Staffordshire have had developed collaborative working arrangements for some time now. The process began with the creation of a handful of committees in common. The CCGs then moved to form a joint executive team.

Governance and legal issues

The amendments to section 14Z3 of the NHS Act 2006, allowing CCGs to utilise joint committees, took effect on 1 October 2014. Relating specifically to the exercise of CCG "commissioning functions" (in this context, the functions of the CCGs in arranging for the provision of services as part of the health service), this enables groups of CCGs to undertake collective strategic decision-making.

CCGs will need to ensure that their constitutions provide for any such joint committee arrangements. These arrangements must also be properly constituted with comprehensive terms of reference. Crucially, the arrangements must stay within the boundaries of section 14Z3 and the NHS Act 2006 generally, and must also observe other legal constraints, for example avoiding "double delegation".

The CCG's constitution must specify the arrangements which have been made for transparency around the joint committees' decisions and the manner in which they are made. CCGs should ensure that the terms of reference for this committee allows appropriate transparency. Passing decision making to a wider decision-making committee such as a joint committee does not supersede the obligations for local scrutiny such as Health and Wellbeing Boards, open meetings and consultation with the local authority which has an overview and scrutiny role.

Clearly, this represents a significant opportunity for CCGs to collaborate and generate efficiencies. Some CCGs may wish to capitalise further on this opportunity with a push towards shared staffing and governance arrangements. However, these shared arrangements entail further legal considerations.

Organisations will need to carefully consider the structure of any organisation created to manage shared staffing arrangements. Any new organisations will also require comprehensive policies, including provisions for staff appraisals, disciplinary procedures and grievances and variations to terms and conditions. Arrangements for insurance, data protection, recruitment and payment services will also need to be taken into account.

CCGs are used to operating pooled budgets, particularly in partnership with local government and as part of the Better Care Fund. There is an option to pool funds across CCGs and to use the pooled budgets to commission patient care. While this is likely to help achieve a more integrated approach, the CCG must ensure their governance arrangements, such as constitution, standing orders and financial instructions, are amended appropriately. Each CCG remains ultimately accountable for commissioning services which meet quality standards and local needs, and this cannot be delegated.

The discussion on legal powers of any future collaborative organisation also considered the impact that these shared arrangements would have on the original governing bodies themselves. While it is clear that significant powers may be delegated to a joint committee, the CCGs themselves will still exist as

Section 14Z3 of the NHS Act (2006)

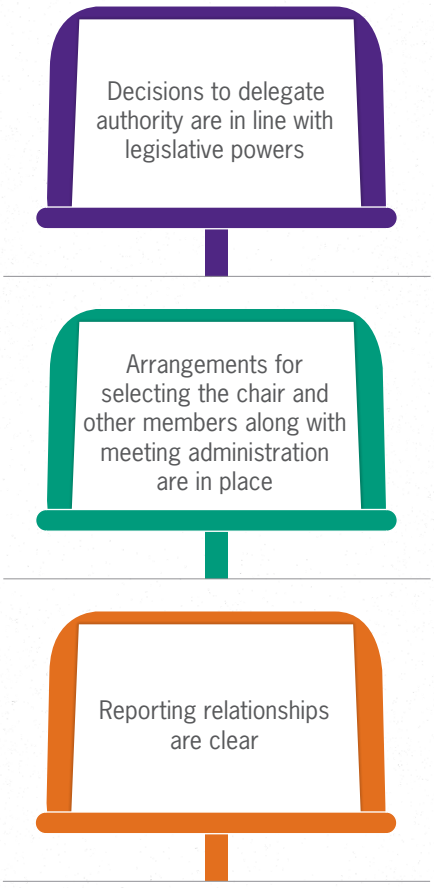
CCGs may make arrangements which allow for:

- one or more CCGs to exercise any of the commissioning functions of another on its behalf (14Z3(2)(a)
- all the CCGs to exercise any of their commissioning functions jointly (s.14Z3(2)(b)(committee in common)
- where any commissioning functions are exercisable jointly by two or more CCGs, a joint committee may be established to exercise those functions (s.14Z3(2A) (joint committee).

CCGs may:

- make/receive payments to/from another CCG
- make/receive the services of its employees or any other resources available to another CCG
- establish and maintain a pooled fund.

From a governance perspective, organisations will need to be clear that:



a statutory body with accountability to their responsible population. Commenting on the impact of committees in common on CCGs in their local area, one participant noted: *"One effect is that the remit of the original governing body becomes very small – essentially, it boils down to the things they can't delegate down … however, governing bodies still carry the can; they must get assurance that people have made the right decision for the right reasons. If I were sat on a governing body, with all of the responsibility and none of the power … that isn't a good model to have in place long-term."*

Sustainability and Transformation Plans (STPs) are important in that they require local government and NHS organisations, including CCGs, to work together to transform services and deliver improvements in efficiency. The issue of governance in STPs was raised by participants in our round table. There is no central guidance on STP governance and, as a result, a variety of approaches have been taken across the country. Clearly it is still early days, but there are areas where governance needs to be developed further. The discussion highlighted:

- clarity on accountability. The STP can be seen as an overlay on top of other arrangements and it is important to identify where responsibilities lie for the individual projects and the STP as a whole
- whether all organisations in the STP area are receiving appropriate assurance that money incurred by the STP is being well spent and performance and quality is good
- how risk management of the STP operates and relates to individual organisations
- whether and how independent chairs are being appointed and how they influence the independent individual organisations in their STP area
- how the legal requirements for bodies with developing relationships and new ways of working are balanced. For example, between CCGs' and local authorities' requirements on the Care Act.

Other issues the roundtable thought needed considering included:

- a need to manage the relationship with Health and Wellbeing Boards as they are well placed to challenge the impact of the changes
- housing not having been given sufficient profile, even though it could have a significant impact on health and wellbeing. This was particularly difficult in two-tiered local authority areas as district councils were often not involved in the STP
- police being better engaged in some areas than others when they have a key role to play on mental health issues in particular[2]
- some STPS finding it harder to engage with regulators, which is particularly important where the STP area includes bodies in special measures
- GPs generally being hard to engage as there is often no one person who can take decisions on behalf of the others.

Some STP areas have responded to these concerns. For example one STP has put a memorandum of understanding in place to make some governance issues clearer. For many others, they have not yet begun to look at these issues and are just at the start of this process.

Culture

Without the appropriate values embedded to support the organisation's plans and objectives or the behaviours required for relevant systems and processes to function at their best, it will be significantly more difficult for an organisation to achieve its desired outcomes and results.

Therefore, for CCGs looking to collaborate on a wider agenda, nurturing the correct culture in their own organisation and between organisations will be a crucial part of navigating the difficult path to increased collaborative working.

Central to the idea of a successful organisational culture is the notion that it should be underpinned by a commonly held set of beliefs and values linked to a common purpose. A common theme from our roundtable discussion was the desire of several participants to move beyond the 'Berlin walls' of the current NHS commissioner/provider dichotomy and reconnect with the idea of "one NHS" and, from a CCG perspective, a "single commissioning voice". Therefore, the idea of an organisation drawn together by a common purpose and a common set of values appears to resonate strongly with many healthcare professionals and is of vital importance if CCGs are to successfully manage the cultural change required to move towards collaborative working.

A good starting point for the kind of cultural change required by CCGs looking to collaborate or even merge is to take time identifying what their current 'norms' are.

CCGs will then need to encourage dialogue around which of these are desirable and likely to support the overall organisational aim.

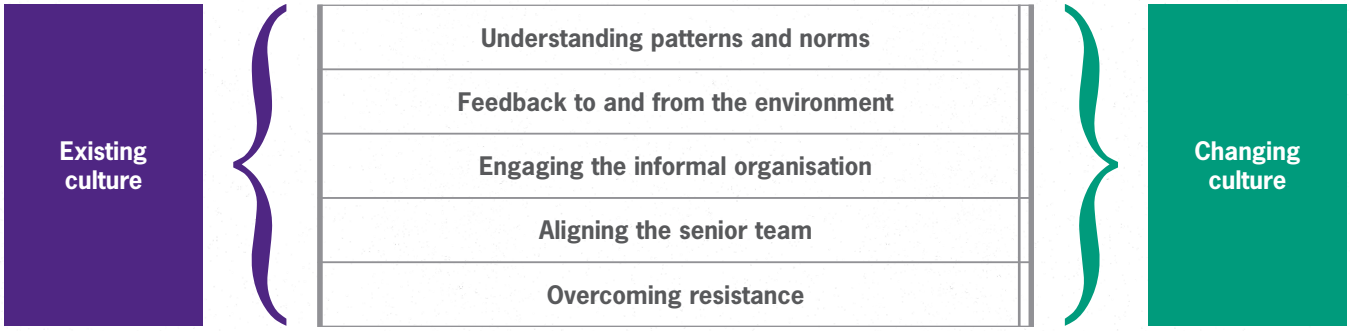
Organisations whose staff are engaged in this way frequently report improved levels of performance, profitability and reduced staff absence. Therefore, engaging in dialogue has the twin benefits of helping to define a common purpose and desired set of cultural norms while simultaneously engendering a sense of ownership and belonging. Ultimately, decisions are taken more effectively in an 'adult to adult' environment.

Organisational culture: "the way we do things around here"

"As the term is most commonly used, it seems to stand for the basic beliefs that people in the business are expected to hold and be guided by – informal, unwritten guidelines on how people should perform and conduct themselves. Once such a philosophy crystallizes, it becomes a powerful force indeed. When one person tells another, 'That's not the way we do things around here,' the advice had better be heeded."

Bower, M., 'The Will to Manage: Corporate Success Through Programmed Management'

How can organisations implement cultural change?



The 'tone at the top' is also key to cementing a new culture. Senior leadership must be aligned around the new cultural cornerstones and willing both to communicate this to all levels of the organisation and lead by example through their behaviour.

Inevitably, as with any change, the kind of adjustment required will encounter resistance. It is important here to distinguish between simple intransigence brought on by inertia or fear of change and genuine challenge. Where the resistance is due to inertia or fear this will need to be overcome by increasing the extent to which people are held accountable against the newly established cultural norms. Genuine challenge should be embraced as it can be a beneficial element of cultural change. Throughout the process it is important to respect individual perspectives and give those resisting a voice. All organisations need effective scrutiny and challenge to leadership and it is important that this is not lost in the clamour of cultural change.

Finally, once an organisation has successfully embedded a new culture, it is vital that work continues to maintain, examine and preserve that culture through maintaining high levels of accountability and behavioural standards.

Tips for CCGs embedding cultural change

1 Focus on leaders first, ensuring consistency of messaging and behaviour. Away days can build trust
2 Develop a common purpose, ie what are we here to deliver together
3 Identify the areas where you fundamentally disagree and develop strategies to overcome. Respectful conversations and avoiding energy-sapping 'dramas' will help
4 Never miss the point that small issues make a big difference and acknowledge this
5 Co-creation of culture and opportunities. Help people find opportunities so that early adopters energise other early adopters. Resistance should be given a voice, so issues get on the table to be resolved

Midlands CCG examples of embedding cultural change and assisting collaborative working

- Allowing staff the opportunity to work flexibly; this engenders a feeling of mutual trust and a sense that all staff were valued employees, crucial in developing the kind of 'adult to adult' dialogue required to encourage a high level of engagement
- Introducing internal email-free days, thereby encouraging genuine dialogue and communication within teams as team members were obliged to seek out and speak to individuals face-to-face or over the phone, instead of resorting to impersonal emails
- Desk sharing and 'hot desking' can break down silos or unspoken hierarchies within an organisation as well as further encourage team members to get to know each other
- Weekly bulletins from the accountable officer to CCG staff

Round table participants

Hazel Buchanan	Director of Operations	NHS Nottingham North & East Clinical Commissioning Group
Karen Brice	Business Consulting Director	Grant Thornton UK LLP
Dr Adrian Canale-Parola	Chair	NHS Coventry and Rugby Clinical Commissioning Group
James Cook	Director	Grant Thornton UK LLP
Mike Emery	Director of Corporate Development	NHS Herefordshire Clinical Commissioning Group
Emily Godson	Associate	Browne Jacobson LLP
Andrea Green	Accountable Officer	NHS Coventry and Rugby Clinical Commissioning Group
Neil Hart	Audit Committee Chair	NHS Warwickshire North CCG
Alison Joyce	Head of Corporate and Legal Affairs	NHS Birmingham Cross-City Clinical Commissioning Group
Dr Barbara King	Clinical Accountable Officer	NHS Birmingham Cross-City Clinical Commissioning Group
Lucy Noon	Director of Governance	NHS South Worcestershire Clinical Commissioning Group
Oliver Pritchard	Partner	Browne Jacobson LLP
David Rowley	Executive	Grant Thornton UK LLP
Dr Deryth Stevens	Clinical Chair	NHS Warwickshire North Clinical Commissioning Group
Alison Smith	Director of Governance	NHS Telford and Wrekin CCG
Terry Tobin	Senior Manager	Grant Thornton UK LLP
Karen Watkinson	Corporate Secretary	NHS Hardwick Clinical Commissioning Group
Sally Young	Director of Corporate Governance, Communications and Engagement	Cannock Chase Clinical Commissioning Group, South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group, Stafford and Surrounds Clinical Commissioning Group

About us

Dynamic organisations know they need to apply both reason and instinct to decision making. At Grant Thornton, this is how we advise our clients every day. We combine award-winning technical expertise with the intuition, insight and confidence gained from our extensive sector experience and a deep understanding of our clients.

Grant Thornton UK LLP is a leading business and financial adviser with client-facing offices in 24 locations nationwide. We understand regional differences and can respond to needs of local authorities. But our clients can also have confidence that our team of local government specialists is part of a firm led by more than 185 partners and employing over 4,500 professionals, providing personalised audit, tax and specialist advisory services to over 40,000 clients.

Grant Thornton has a well-established market in the public sector and has been working with local authorities for over 30 years.
We are the largest employer of CIPFA members and students in the UK. Our national team of experienced local government specialists, including those who have held senior positions within the sector, provide the growing range of assurance, tax and advisory services that our clients require.

We are the leading firm in the local government audit market. We are the largest supplier of audit and related services to the Audit Commission, and count 35% of local authorities in England as external audit clients. We also audit local authorities in Wales and Scotland via framework contracts with Audit Scotland and the Wales Audit Office. We have over 180 local government and related body audit clients in the UK and over 75 local authority advisory clients.

This includes London boroughs, county councils, district councils, city councils, unitary councils and metropolitan authorities, as well as fire and police authorities. This depth of experience ensures that our solutions are grounded in reality and draw on best practice. Through proactive, client-focused relationships, our teams deliver solutions in a distinctive and personal way, not pre-packaged products and services.

Our approach draws on a deep knowledge of local government combined with an understanding of wider public sector issues. This comes from working with associated delivery bodies, relevant central government departments and with private-sector organisations working in the sector. We take an active role in influencing and interpreting policy developments affecting local government and in responding to government consultation documents and their agencies.

We regularly produce sector-related thought leadership reports, typically based on national studies, and client briefings on key issues. We also run seminars and events to share our thinking on local government and, more importantly, understand the challenges and issues facing our clients.

Contact us

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