

Options for integrated commissioning

Beyond Barker

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1 Introduction

It is now universally recognised that health and social care services need to be much better co-ordinated around the individual to ensure that the right care is offered at the right time and in the right place.

Although integrated care has been a longstanding policy aspiration of successive governments, progress has been limited and patchy. This reflects fundamental differences between the NHS and the social care system in terms of funding, governance and accountability, dating back to the establishment of the National Health Service in 1948. Since then there have been decades of social, demographic and technological change, including major shifts in the pattern of disease. Despite these changes, stark divisions remain between the NHS – used by most of the population, funded through taxation and free at the point of use – and social care – increasingly limited to those with the highest needs and fewest means.

In 2013 The King's Fund established an independent commission, chaired by Kate Barker, to consider whether, and how, the boundary between health and social care could be drawn, focusing on how entitlements to these services and their funding could be better aligned.

The Commission on the Future of Health and Social Care in England (Barker Commission) was especially exercised by the lack of alignment between the NHS and social care in the way that services are funded and commissioned. Its central recommendation was that 'England moves to a single, ring-fenced budget for health and social care, with a single commissioner' ([Commission on the Future of Health and Social Care in England 2014a](#)), something which it saw as fundamental to achieving a much more joined-up health and social care system.

Since the publication of the final report in September 2014 The King's Fund has tested and discussed the Barker Commission's findings and recommendations with stakeholders from charities and patient/service user organisations, national bodies representing professions and organisations in the NHS and local government, as well as academic and technical experts. These discussions indicate a substantial



groundswell of support for the central proposition of a new settlement based on a single ring-fenced budget and a single local commissioner. But the biggest concern expressed by stakeholders – especially from within the NHS and local government – was how a new settlement could be achieved without major organisational change, to which there is almost universal aversion.

In the light of these views The King’s Fund has focused its subsequent work on exploring options for putting in place a single commissioning arrangement with a ring-fenced budget covering both health and social care. This has involved:

- a desk review of existing evidence and experience, drawing on examples from our integrated care networks and intelligence, and from current work in Scotland
- a small online survey to gauge the extent of existing joint or integrated commissioning arrangements, pooled budgets and the role of health and wellbeing boards
- an invitation-only seminar with local systems that are in the forefront of developing integrated commissioning, for example, the Better Care Fund ‘fast track’ systems and integration pioneers
- a national conference – ‘Towards integrated commissioning’ – held on 27 January 2015 – that attracted significant interest from the field and from policy-makers.

This paper draws together all this work. It outlines the case for integrated health and care services; assesses the evidence of past attempts at joint commissioning and the current policy framework; describes some current local innovations in integrated budgets and commissioning, including the development of new integration boards in Scotland; and considers the potential of health and wellbeing boards to have a wider commissioning role and the changes that would be required for this to happen. It also discusses the implications of recent policy developments, notably the devolution agenda in local government and the Greater Manchester proposals, the shift of primary care commissioning to clinical commissioning groups (CCGs) and the proposed delivery models in the *NHS five year forward view* (Forward View) (NHS England et al 2014).



2 Why integrated care?

The case for better integration between different types of health services and between health and care services is now universally accepted. Evidence on integrated care to date is mixed and success can depend on local context. Measuring its impact is difficult, and in many cases the results take years to materialise (Ham *et al* 2015; Bardsley *et al* 2013). Nevertheless, there is sufficient evidence that integrated care is the right direction of travel for meeting the changing needs of the population, particularly in the context of increasing numbers of older people and people with long-term and complex conditions. What is clear is that fragmented and disjointed care have a negative impact on patient experience, result in missed opportunities to intervene early, and consequently can lead to poorer outcomes. Poor alignment of different types of care also risks duplication and increasing inefficiency within the system (Department of Health 2013).

There is no single definition for integrated care, and the integration of services can take place in various forms and at different levels. For example, services may be integrated at the level of a local or regional population, for a particular care or age group, or at an individual level, or indeed may involve more than one of these approaches. To provide a shared understanding of integrated health and care, the government (and others) has adopted a ‘person-centred co-ordinated care’ definition that focuses on the individual as the organising principle for services (Department of Health 2013).

There is emerging evidence that the integration of health and care services can produce a range of benefits. This is particularly the case for local or regional populations and for older people, and there is also evidence that care co-ordination can benefit individual service users and carers (Ham and Curry 2010b). In particular, service integration is associated with improvements in patient experience (a central part of the government’s definition of integrated care) and higher levels of patient satisfaction (Ham and Walsh 2013). Where effective, integration of services overcomes many of the negative consequences of a fragmented system from the user’s perspective, such as the need for multiple assessments and visits to different



providers. This in turn improves the experience of care. The use of care plans to ensure a smooth transition between providers has also been shown to produce high levels of patient satisfaction (Ham and Curry 2010a).

Integrated care has also been shown to lead to improved clinical outcomes, including a reduction in the use of acute and emergency care through better co-ordination with primary and community care services. In the context of older people, there are particular opportunities for integrating care, from prevention through to specialist services. Integrated care models have been able to support individuals to remain within their communities and to counter threats to their independence (Ham and Walsh 2013). Other evidence has shown that the impact of integrated care and community-based interventions has been mixed; it also recognises that it may take much longer for the results of these interventions to show themselves (Bardsley et al 2013).

Integration of care has also been shown to improve service efficiency in some cases, with examples of international integrated providers demonstrating that they can provide high-quality services at a lower cost than their competitors (Ham and Curry 2010a). A reduction in duplication between services, as well as a decrease in the use of acute care in favour of community and home care may also lead to cost savings. In the 2013 Department of Health publication *Integrated care and support: our shared commitment*, the national partners emphasised their ambition for truly integrated care and support to deliver better outcomes for less money (Department of Health 2013).

Importantly, there is clear evidence that when it comes to delivering benefits, the integration of clinical teams and services is far more important than the integration of organisations – and organisational integration in itself is no guarantee of improved outcomes (Ham and Curry 2010b). Instead, the successful integration of services is dependent on having a shared purpose and a clear vision of what integrated care will achieve. It is important that attempts to integrate care move beyond high-level aspirations and involve the development of specific objectives (Ham and Walsh 2013).

A strong message from all of this work is that integration is not an end in itself but a means to better outcomes. Recognising this, the government commissioned



advice at the end of 2013 on the development of indicators for measuring progress on integrated care ([Raleigh et al 2014](#)). Clarity about the outcomes that integrated care is designed to achieve should be the first consideration in developing any new arrangements.



3 Why integrated commissioning?

Against this background it is clear that commissioning has a key role to play in developing integrated services, and that the ongoing separation between the health and social care systems is a major obstacle to achieving better outcomes for people.

In its interim report the Barker Commission identified a lack of alignment between the NHS and social care systems in three areas. First, NHS care is free at the point of use while social care is means-tested. Second, the NHS is almost entirely tax-funded and operates within a ring-fenced budget while the social care budget is not ring-fenced and local authorities determine local spending. Finally, there is a lack of organisational alignment between the health and social care systems, largely as a result of the two services being commissioned separately ([Commission on the Future of Health and Social Care in England 2014b](#)).

The Barker Commission highlighted in particular the problem of increasing fragmentation of commissioning responsibilities between different organisations within the NHS and local government. Its principal recommendation was that England moves to a single, ring-fenced budget for health and social care which is singly commissioned. The Barker Commission acknowledged that ‘moving to a single budget with a single commissioner is not a *sufficient* condition to tackle the myriad problems of integration that face health and social care. But we believe it is a *necessary* one’ ([Commission on the Future of Health and Social Care in England 2014a](#)).

The House of Commons Health Committee’s inquiry on the future of social care also highlighted the problem of fragmented commissioning budgets. The inquiry concluded that attempts to address this problem by ‘building bridges’ between services had not worked, and that truly integrated services would not be achieved without the establishment of a single commissioner ([House of Commons Health Committee 2012](#)). Subsequent Health Committee reports have reiterated the problem of fragmented commissioning arrangements as an obstacle to truly integrated services.



The Independent Commission on Whole Person Care chaired by John Oldham also highlighted the challenges that fragmented commissioning and financial arrangements pose for the delivery of person-centred care. It set out a vision for ‘community commissioning’ based on bringing together separate health and social care budgets across a local area (Oldham 2014).

The adequacy of current commissioning arrangements is also called into question by the development of the new delivery models proposed in the Forward View (NHS England et al 2014). The multispecialty community provider (MCP) model, for example, would require integrated commissioning – bringing together the budgets of CCGs and NHS England (in respect of primary care) and in some cases of local authorities where the MCP will provide social care (Ham and Murray 2015). Another care model outlined in the Forward View is primary and acute care systems (PACS) described as ‘single organisations to provide NHS list-based GP and hospital care, together with mental health and community care services’ (NHS England et al 2014). It has been argued that the potential power of large integrated providers would need to be counteracted by much stronger strategic commissioning so that they are held to account for the delivery of agreed outcomes for individuals and populations (Ham et al 2013). It is hard to see this happening under the current fragmented commissioning arrangements.

There is growing interest also in the potential of accountable care organisations in which a group of providers agrees to take responsibility for providing all care for a given population for a defined period of time under a contractual arrangement with a commissioner. Providers are held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target (Shortell et al 2014).

All of these models will require fundamental changes to commissioning so that there is a much more strategic and integrated approach to the planning and use of resources, both within the NHS and between the NHS and local government.

The Independent Commission on Local Government Finance endorsed the Barker Commission’s recommendation for a single spending settlement. It has gone further by recommending the introduction of place-based budgets covering a wide range of local budgets for places that are willing and able to take on this reform (Chartered Institute of Public Finance and Accountancy 2015). This reflects a growing interest in the devolution of responsibilities and resources from Whitehall to local areas, perhaps



best exemplified in Greater Manchester’s proposals for a combined health and social care budget (discussed later in this paper).

However, while calls for a more integrated approach have been fuelled by widespread dissatisfaction with the complex organisational landscape bequeathed by the Health and Social Care Act 2012, most commentators acknowledge that there is a deep aversion to further structural change. This raises a fundamental question as to whether a shift towards integrated commissioning is possible without significant changes in the number, roles and functions of existing organisations. The Barker Commission did not have time to explore options for a single commissioner in detail; however, it did note the Health Committee’s suggestion that health and wellbeing boards evolve to become the appropriate organisation for this role. This option and others are explored in further detail later in this paper.

During the election campaign each of the main parties committed to the integration of health and social care in their manifestos. The Conservative Party, now elected with an overall majority, has said it ‘will continue to integrate the health and social care systems, joining-up services between homes, clinics and hospitals, including through piloting new approaches like the pooling of around £6 billion of health and social care funding in Greater Manchester and the £5.3 billion Better Care Fund’ ([Conservative Party 2015](#)). It seems likely that cross-party support for health and wellbeing boards will continue.



4 Policy context and evidence

The value of joint working between health and social care services (and between health services) has long been recognised. Since the 1970s policy-makers have introduced a range of initiatives intended to achieve a closer alignment of NHS and social care resources. These have included:

- the introduction of joint consultative committees, joint planning teams and joint finance in the 1970s and 1980s
- a requirement to produce jointly agreed community care plans as a result of the community care reforms in the 1990s
- the introduction of new legal powers for pooled budgets, lead commissioning and integrated provision through the Health Act 1999
- the creation of a new option of care trusts as a single local integrated care organisation, as part of the NHS Plan 2000
- new statutory local area agreements (LAAs) placing a duty on named partners to co-operate with the LAA and the creation of local strategic partnerships (Local Government and Public Involvement in Health Act 2007).

More recently, integration has been an explicit policy priority of the coalition government since 2010. Although this was not originally a feature of the Health and Social Care Act 2012, amendments saw it place new duties on organisations to promote integrated care and retain the previous legislative flexibilities for pooled budgets, lead commissioning and integrated provision. The 2012 Act also introduced health and wellbeing boards as a new local vehicle to promote integration. They have a statutory duty to promote integration, assess the needs of their local population through a joint strategic needs assessment and agree a health



and wellbeing strategy that sets out how those needs will be met. The Care Act 2014 reinforced duties on various organisations to promote integrated care.

However, the Health and Social Care Act 2012 seriously fragmented responsibility for commissioning, with population-based budgets formerly controlled by primary care trusts (PCTs) now split between 211 CCGs, NHS England and 152 local authorities.

In May 2013 the government announced an Integrated Care and Support Pioneers programme, intended to lead the way in transforming services and improving integration. In November 2013, 14 initiatives were selected for the programme from different localities, with a range of approaches to transformation, including new approaches to commissioning. A second wave of the programme was announced in January 2015 involving another 11 sites. Early reports from pioneers are encouraging ([NHS England 2014b](#)).

In 2013 the government also announced the Better Care Fund – a local, single, pooled budget intended to incentivise the NHS and local government to work more closely together and to work on integrating services. The original intention was for the fund to support adult social care services that have health benefits, helping people to remain healthy and independent within the community. Following a revision to the policy in summer 2014, the emphasis changed to reducing emergency hospital admissions and achieving financial savings, with a proportion of the fund now linked directly to performance against these goals ([NHS England 2014a](#)).

All local areas were required to develop a Better Care Fund plan led by health and wellbeing boards, and with sign-off from local authorities and CCGs. All plans have now been approved, with three areas receiving ongoing support. Where there is not already one in place, localities are required to establish a partnership board with representation across the relevant CCG(s) and the local authority (or authorities) to govern the pooled funding arrangements ([NHS England 2015](#)).

The Better Care Fund is an important step towards a single budget. Although it covers only a number of specified services, local authorities and CCGs can continue to use wider flexibilities to pool their funds in other areas. Nonetheless, the fund represents less than 5 per cent of total spending on the NHS and social care. While



health and wellbeing boards are responsible for the strategic direction of the fund and its role in the delivery of more integrated care, CCGs and local authorities will remain accountable for their respective contributions to it (NHS England 2015). Some areas have used the Better Care Fund as the basis for moving towards more formalised joint commissioning arrangements (discussed in more detail below). But concern has been expressed that changes to the fund have undermined its core purpose in promoting locally led integrated care, have reduced the resources available to protect social care and have eroded local goodwill. Better Care Fund plans have been described as containing ‘bold assumptions’ about expected reductions in emergency admissions and financial savings (National Audit Office 2014). The impact of the Better Care Fund will become clear only when it is implemented from 2015/16.



5 Evidence and experience

This section outlines some of the findings from a review of the research, and the key messages from our own and other surveys. We then describe examples of places that are moving towards more formalised joint commissioning arrangements.

Although efforts to develop joint approaches to commissioning by local authorities and their NHS partners have been an important feature of many integration initiatives, in practice they have taken a range of different forms and have been associated with a wide variety of objectives and outcomes (Hudson 2011).

Joint commissioning can also take place at different levels – for example, on a geographical level, covering all services within a certain place; through team- or practice-level commissioning, covering some services for certain groups; and commissioning at an individual level for specific service users. Alternatively, joint commissioning may be described as strategic, involving full integration of organisations' governance processes, and operational, involving partial integration relating to service provision (Glasby 2012).

While there is no universal definition of joint commissioning, it is possible to identify a set of arrangements and mechanisms that are commonly associated with its practice (a number of these are outlined in Appendix 2).

Overall the research suggests that examples of fully integrated commissioning are limited, and that this approach is typically confined to a small number of service areas. It follows that research into the nature and, in particular, the effectiveness of joint commissioning is also relatively limited. Collecting robust information on outcomes is complicated by the challenge of isolating the impact of commissioning arrangements, and the absence of a counterfactual. The evidence that is available suggests that the nature and success of integrated commissioning arrangements varies significantly between local areas and between services. This picture is supported by the findings from our survey of local authorities and CCGs, and other research.



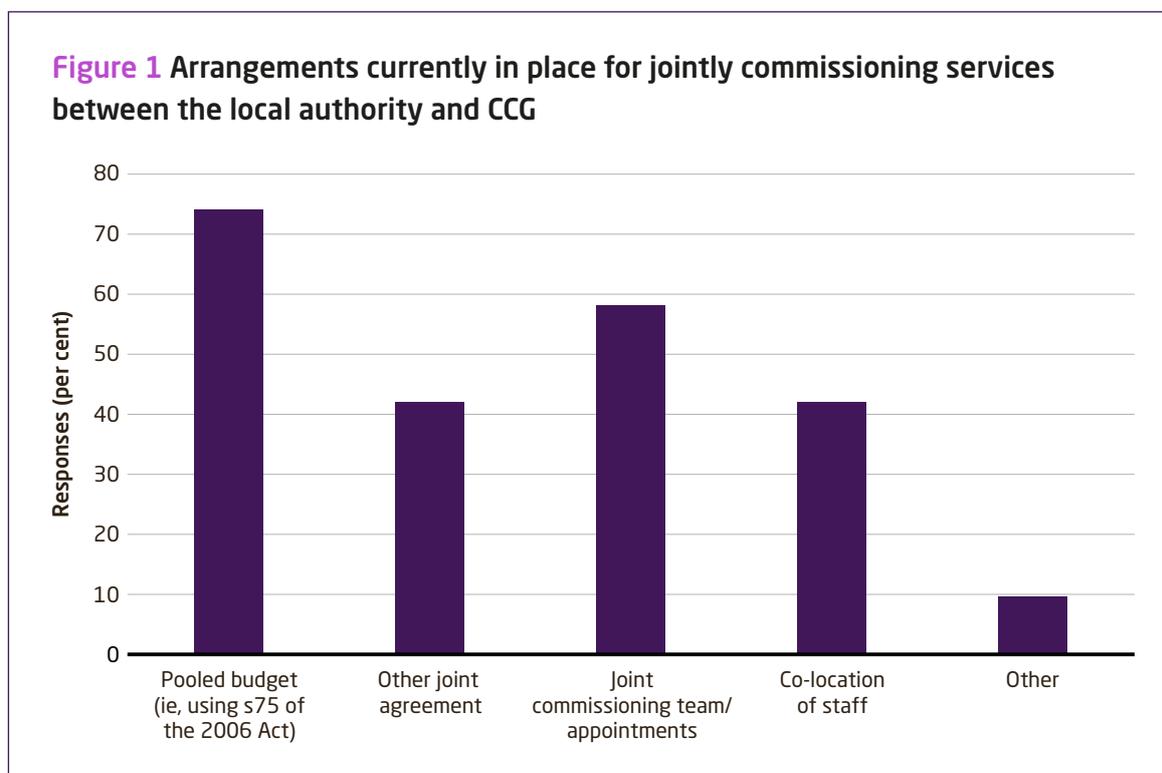
Use of joint arrangements

On the basis of a study of five joint commissioning case study sites, Glasby and colleagues concluded that the nature and scope of joint commissioning arrangements vary significantly between areas and that to a large extent these arrangements are shaped by the local context. The study also found that many of the practices described by the study sites were not confined to joint commissioning specifically, but could be linked to joint working in general. Although some of these were longstanding examples of good practice, they struggled to demonstrate a positive impact on outcomes (Glasby *et al* 2013). Similarly, a review of the care trusts established during the 2000s noted that local relationships and needs were the most important factor in their development (Miller *et al* 2011).

A report by the Audit Commission on joint financing arrangements in 2009 also noted that partnership arrangements tend to be tailored to local circumstances, and that relationships are a key factor in determining the way in which these arrangements are developed and operate (Audit Commission 2009). Of the various mechanisms that facilitate joint working (described in more detail in Appendix 2), pooled budgets (using section 75 agreements) appear to be one of the most widely used. The Audit Commission's report noted that pooled funds were most commonly in use in the context of services for people whose needs spanned health and social care, such as learning disabilities, mental health and community equipment services (Audit Commission 2009). An earlier evaluation of the flexibilities in the 1999 Health Act identified particular benefits from the use of lead commissioning in removing duplication in commissioning and contracting (Glendinning *et al* 2002).

A recent review of international integrated health and care funding arrangements also noted the widespread use of joint budgets as a means of promoting integrated care. The review explored some of the challenges associated with the implementation of these arrangements and in particular stressed the importance of their being underpinned by effective working relationships and leadership across the system (Mason *et al* 2015).

The King's Fund carried out a joint commissioning survey of local authorities and CCGs. A total of 31 surveys, representing 33 organisations, were completed. Our survey found that many organisations are currently making use of the mechanisms that support joint commissioning, but that the nature and scope of these arrangements varies widely between localities and even services. All respondents



had some arrangements in place for joint commissioning. As shown in Figure 1, nearly three-quarters (74 per cent) are operating pooled budgets, and 68 per cent are working in joint teams and/or with joint appointments.

Consistent with the Audit Commission's findings, responses to the survey showed that these arrangements are most commonly applied to mental health services and services for those with learning disabilities, with nearly one-third of those responding suggesting that 100 per cent of these budgets were subject to joint arrangements. However, when asked about the proportion of the total commissioning budget subject to joint arrangements, responses ranged widely from less than 2 per cent to 100 per cent.

Respondents were also asked about their plans to introduce further arrangements for joint commissioning within the next 12 months. Of the total respondents, 77 per cent indicated that they would be introducing pooled budgets – unsurprising in the context of the Better Care Fund, which we discuss later.

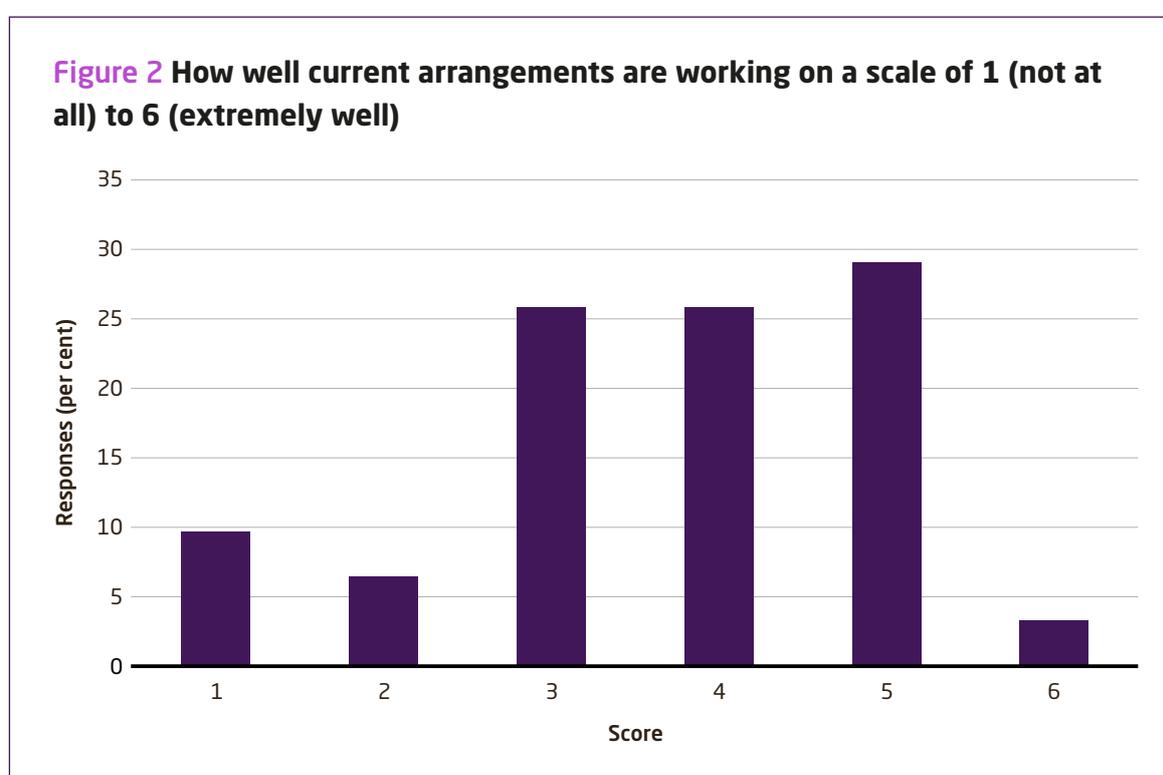


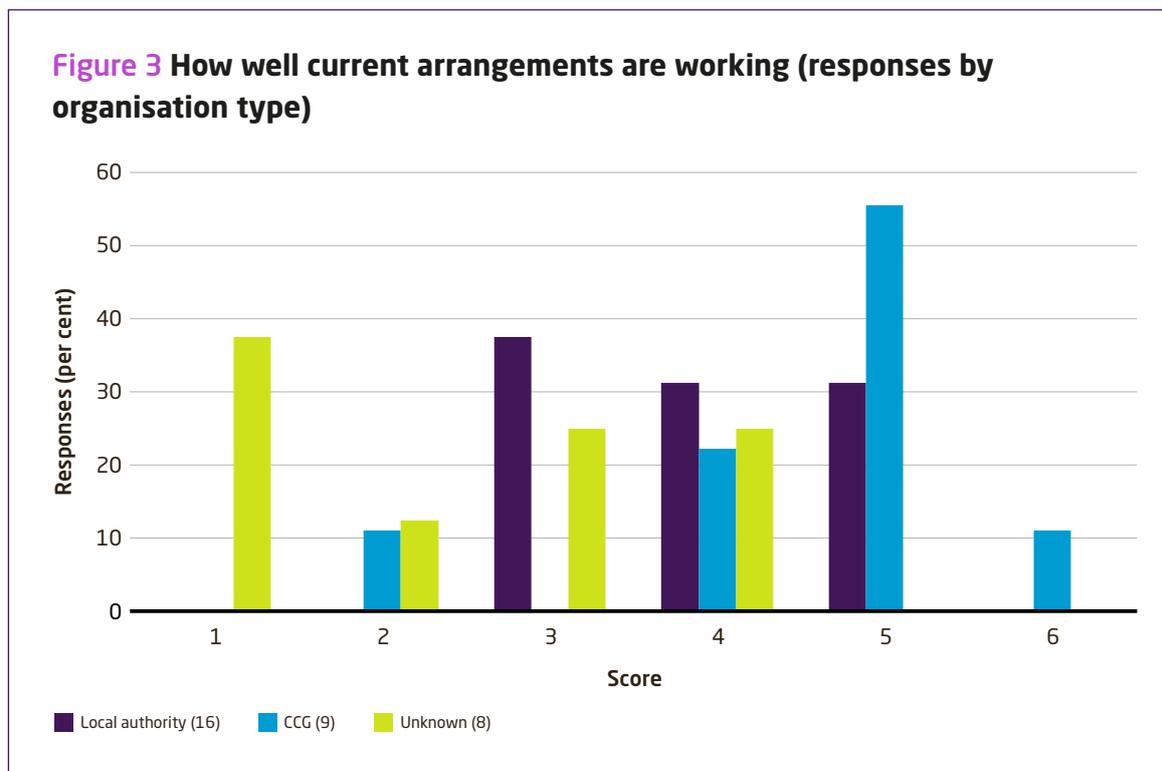
Effectiveness of joint arrangements

Glasby's review of case study sites also noted that a wide range of objectives have been associated with joint commissioning, and consequently that different approaches are used to measure the success of these arrangements (Glasby *et al* 2013).

Our survey asked respondents to score their joint arrangements on a scale of one to six in relation to how well they are working in meeting the needs of their local population, where a score of one indicated 'they do not work at all' and six indicated that they 'work extremely well'. More than half (58 per cent) scored these arrangements as four or higher, with only 16 per cent awarding a score lower than three (Figure 2).

While this appears to suggest that joint arrangements are generally considered successful, respondents' comments provided some qualification to this, with a few emphasising that the effectiveness of these arrangements varies significantly between services. Moreover, when responses are broken down by provider type





(see Figure 3), it appears that CCGs are noticeably more positive about these arrangements than local authorities (although the small sample size cautions against reading too much into this).

Respondents also provided a range of views in response to questions about the role of the Better Care Fund in using resources more effectively across health and social care. Those responding to the survey were asked to provide a score between one and six, where a score of one indicated that the Better Care Fund was ‘unimportant’ or would have ‘no impact’ in the effective use of resources, and a score of six indicated that it would be ‘very important’ or have a ‘high impact’. As shown in Figure 4, almost equal numbers gave this a score lower than four (48 per cent) as they did of four or higher (52 per cent). The broad trend remained when responses were broken down by provider type (Figure 5), and is underlined by respondents’ free text answers: while some consider the Better Care Fund to be a focus or driver for more effective joint working, with a number indicating plans to go far beyond the minimum requirements, others see it as a distraction and overly bureaucratic.



Figure 4 How important the Better Care Fund will be in using resources more effectively on a scale of 1 (unimportant) to 6 (very important)

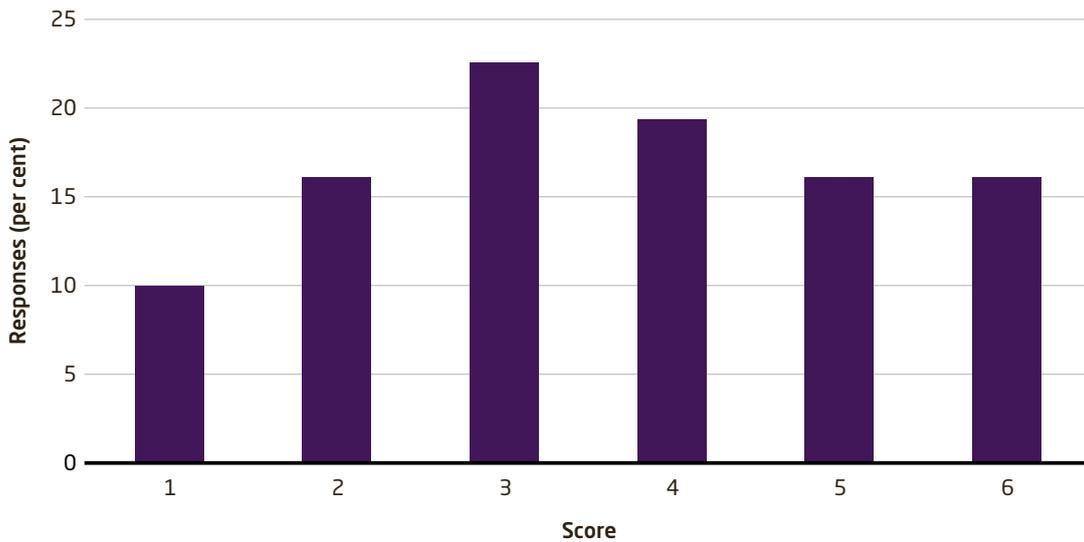
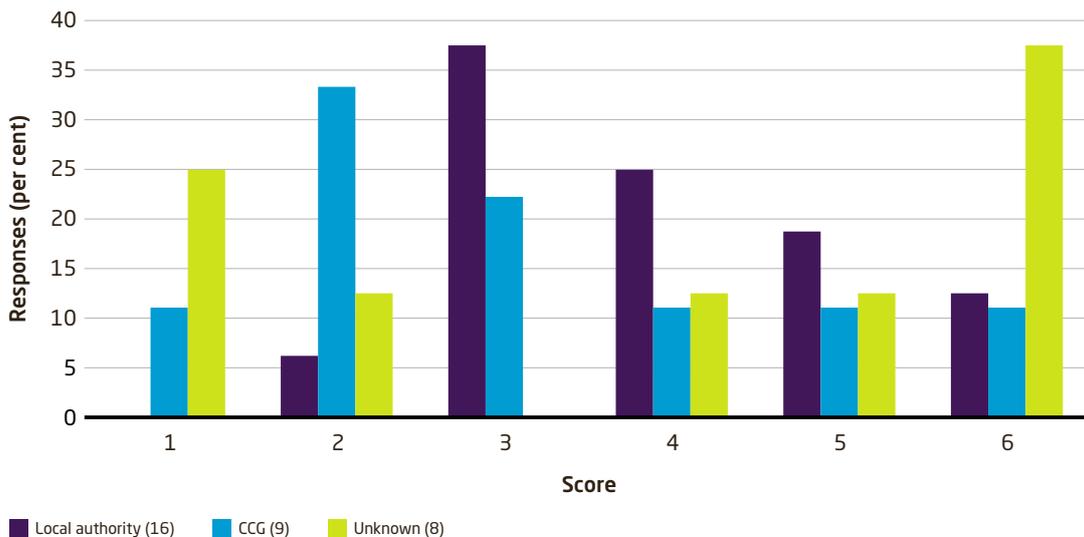


Figure 5 How important the Better Care Fund will be (responses by organisation type)

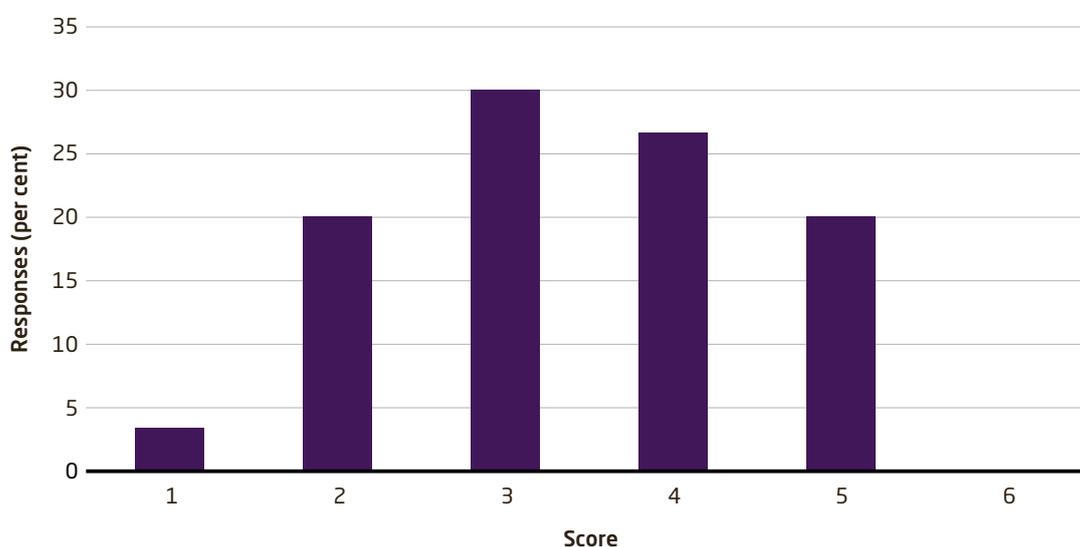




Health and wellbeing boards and other partnership vehicles

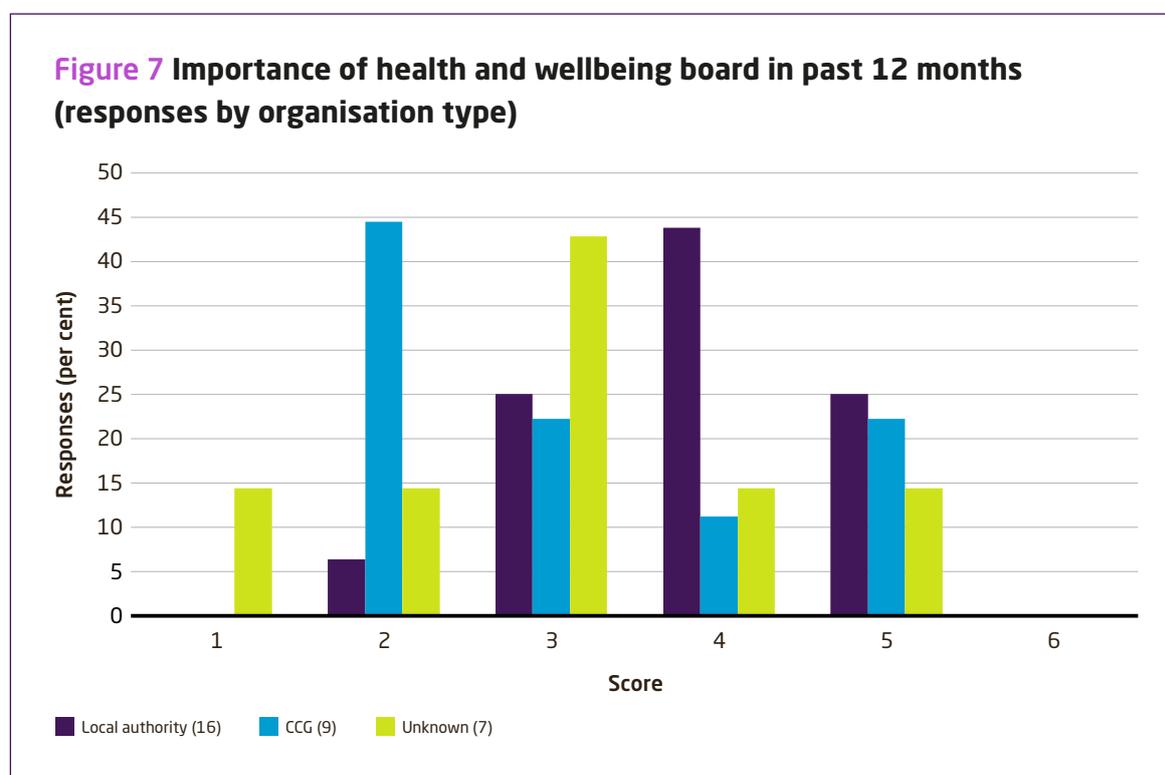
As set out earlier, health and wellbeing boards were introduced by the Health and Social Care Act 2012 as a new mechanism for promoting joint working between local organisations. However, responses to our survey showed that views on the importance and impact of health and wellbeing boards are mixed. Respondents were asked to score their health and wellbeing board on a scale of one to six in terms of its importance in promoting integration, with one implying it was not important and six that it was extremely important. Most respondents (57 per cent) scored their health and wellbeing board as three or four, with an equal number (20 per cent) awarding a score of two and five (Figure 6). It is worth remembering, however, that health and wellbeing boards are still very new and many of these arrangements are still bedding in, a point emphasised in some respondents' free text comments.

Figure 6 In the past 12 months, how important has the health and wellbeing board been in promoting integration on a scale of 1 (not important) to 6 (extremely important)





When broken down by provider type it seems that, in contrast to views on current arrangements, local authorities are more positive in their assessment of the health and wellbeing board's importance than are CCGs: 67 per cent of CCGs rated their health and wellbeing board as three or lower on a scale of importance, while 69 per cent of local authorities awarded their health and wellbeing board a score of four or higher (Figure 7). Given that local authorities typically host health and wellbeing boards, this may reflect a sense among CCGs that their influence over their health and wellbeing board is limited.



There appears to be slightly more agreement on the degree of influence that health and wellbeing boards have had in developing Better Care Fund plans, with 60 per cent overall scoring this as three or lower (Figure 8). However, once again responses from CCGs were more negative than were those from local authorities (Figure 9).



Figure 8 How influential the health and wellbeing board has been in developing local Better Care Fund plans on a scale of 1 (not important) to 6 (very important)

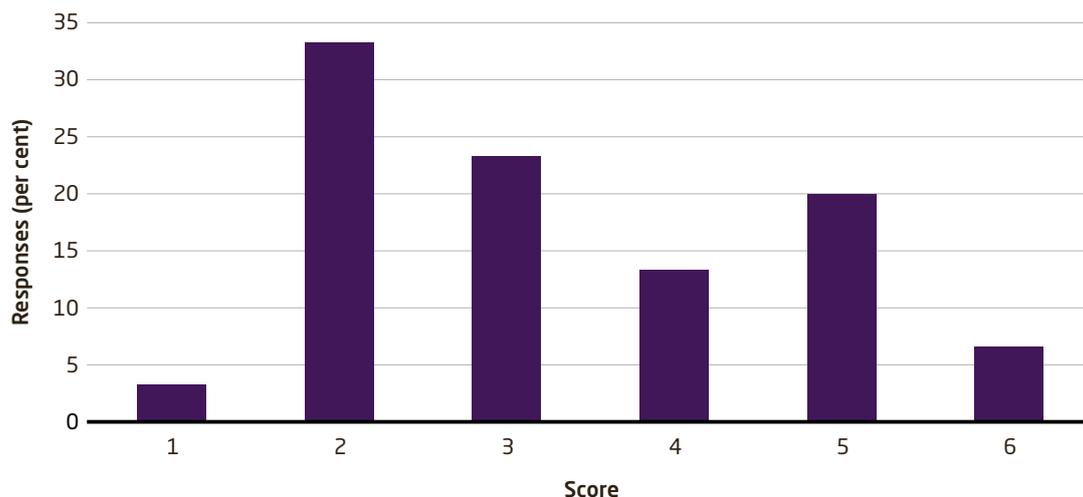
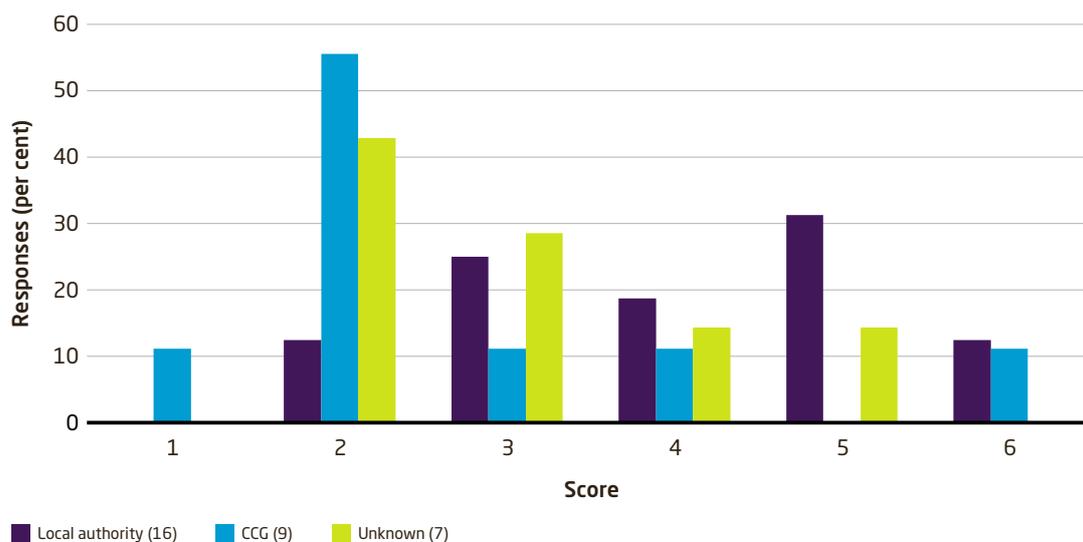


Figure 9 Influence of health and wellbeing board in Better Care Fund plans (responses by organisation type)





These findings are consistent with previous surveys of health and wellbeing boards' progress conducted by The King's Fund ([Humphries et al 2012](#); [Humphries and Galea 2013](#)). These found that although many health and wellbeing boards were making good progress in developing relationships and were beginning to address public health issues, there were wide variations in how well they were performing and in their capacity for future development. Most health and wellbeing boards signalled an aspiration to play a bigger role in commissioning both health and social care services for their local population but there was little sign that they had begun to grapple with the immediate and urgent challenges facing their local health and care economy.

More recent surveys of health and wellbeing boards by London Councils and the Local Government Association paint a similar picture, with few providing genuine system leadership despite ambitions to do so. Obstacles to progress included national and local pressures to address issues which are not locally prioritised; focusing on the health and wellbeing board as a local authority committee meeting rather than a set of local relationships; and limited engagement of providers ([Local Government Association 2015](#); [London Councils 2015](#)).

The majority of respondents to our survey suggested that other partnership arrangements or vehicles are in place within their local health and care economy currently, in addition to the health and wellbeing board. Many referred to some form of joint commissioning team or board, sometimes in relation to a specific set of services, while others referred to local transformation programmes. However, the overarching picture is again one of local variation, with a variety of different organisations being named. Responses to a question about other arrangements in place ranged from 'none' to 'too many to list'.



6 Examples and developments

This section sets out some current examples of areas that are pursuing more formalised integrated commissioning arrangements, often using the Better Care Fund as a basis. It also outlines the plans for devolution in Great Manchester, and the experience in Scotland, where recent legislation has provided a legal basis for the integration of health and social care commissioning throughout the country.

The arrangements described below are by no means the only examples of joint commissioning within the United Kingdom, but they do focus on places with ambitious, large-scale plans to bring together commissioning and budgets.

North East Lincolnshire

Health and adult social care have been jointly commissioned in North East Lincolnshire since 2007. Until 2013 this was the responsibility of North East Lincolnshire Care Trust Plus. However, following the implementation of the Health and Social Care Act 2012, this was replaced by North East Lincolnshire CCG. North East Lincolnshire CCG now acts as integrated commissioner with responsibility for commissioning health and adult social care services. This arrangement is based on a section 75 agreement with North East Lincolnshire Council that sets out the delegation of commissioning responsibility for adult social care to the CCG, as well as arrangements for a pooled budget.

These arrangements are reflected in the CCG's governance structure: although the CCG's governing body is responsible for final strategic decisions, the CCG has a partnership board (a sub-committee of the governing body), made up of members of the CCG and the council, that meets every two months to discuss the CCG's strategic direction. This structure was developed as a means of giving the local authority a strategic role in the organisation, without including local authority representation on the CCG's governing body – something not allowed under the Health and Social Care Act 2012.



The CCG's strategic plan for 2014/19 identifies the integration of commissioning health and adult social care as a first step towards becoming an outcome-based commissioning organisation ([North East Lincolnshire Clinical Commissioning Group 2014](#)).

Sheffield

Sheffield CCG and Sheffield City Council have agreed to work towards a single budget for health and social care, building on the foundation laid by the Better Care Fund. The two organisations are planning a pooled budget of £270 million to include all current expenditure in four areas – preventive care, independent living solutions such as community equipment and adaptations, active support and recovery, and long-term high-support care for people needing ongoing care, including continuing health care. It will also include NHS expenditure on non-surgical emergency admissions to ensure a shared commitment to reduce emergency admissions.

To lead delivery of their integrated commissioning work, the CCG and local authority have established an executive management group jointly chaired by both organisations. This group is responsible for developing joint commissioning strategies within the overall direction set by the health and wellbeing board; implementing commissioning plans; operation of the section 75 partnership; and overseeing individual schemes and service contracts. The intention is that this will ensure that the organisations make joint decisions on all aspects of care and expenditure within the remit of the pooled budget. For example, it will mean that they have a shared responsibility for achieving the agreed objectives ([Sheffield Clinical Commissioning Group *et al* 2014](#)).

Northern, Eastern and Western Devon and Plymouth

As part of their 'One system, one budget' vision for integrated health and wellbeing, Northern, Eastern and Western Devon CCG and Plymouth City Council are in the process of establishing a fully integrated commissioning function.

These arrangements build on existing joint commissioning arrangements, including co-location of the CCG and council. Initially it will be driven by four 'integrated commissioning strategies' for wellbeing, children and young people, complex care and community-based care.



In order to provide integrated system leadership the organisations have established an integrated commissioning board. This will act as the single health and wellbeing commissioning body for the population of the city of Plymouth, providing commissioning leadership and ensuring the delivery of integrated commissioning in line with their joint health and wellbeing policy through the four integrated commissioning strategies. Its membership spans the CCG, council, police and crime commissioner, police and probation services and it will be accountable to the health and wellbeing board for its progress.

Underpinning these arrangements is an integrated fund of approximately £460 million, consisting of a £131 million net contribution from the council and a £331 million net contribution from the CCG. The fund comprises pooled and aligned funding arrangements, and is supported by a risk share and financial framework. It incorporates all commissioning budgets for the four service areas covered by the integrated commissioning strategies ([Plymouth City Council 2014](#)), which spans not just health and social care commissioning, but housing, leisure and public health too.

Dorset, Bournemouth and Poole

Dorset County Council, with Bournemouth and Poole Councils and Dorset Clinical Commissioning Group, has established a single joint commissioning board to agree the strategic direction, commissioning, monitoring and review of health and social care services for adults and older people across the three local authority areas. The remit of the board includes overseeing the use and development of the Better Care Fund pooled budget, to agree delegated authorities for commissioning frameworks and to agree further pooled budget arrangements.

The board is accountable to the CCG board, the two health and wellbeing boards (Dorset, and Bournemouth and Poole) and the cabinets of the three local authorities. It submits an annual report to these bodies describing how it has discharged its delegated responsibilities and with a commentary on performance of providers, financial pressures and changes in need or service delivery. The annual report also sets out commissioning intentions for the coming year.



Southend

Southend is one of the first 14 localities involved in the Integrated Care and Support Pioneers Programme (the first wave was selected in November 2013). As part of their ambition for a truly integrated health and social care system, local organisations in Southend are seeking to change the way that health and social care is commissioned and have begun work to develop their vision for an integrated commissioning function.

Local organisations in Southend have a track record of working together, first through a strategic alliance and then via the joint executive group, made up of the council, CCG and provider organisations. In August 2014, Southend CCG and Southend-on-Sea Borough Council agreed a memorandum of understanding setting out the basis for a longer-term commissioning relationship. On 1 April 2015 the joint commissioning team was formally brought together with the appointment of a joint associate director of integrated care commissioning and a head of integrated care. The services specifically targeted include mental health, learning disabilities, frail older people's care and children's services.

Key focus areas for the joint commissioning team include the jointly agreed work plan and co-location of commissioning teams from both health and social care.

However, the function of the joint commissioning team does not involve any immediate transfer of statutory responsibilities between the organisations. Further, where integration of health and social care commissioning requires transfer of responsibility in the longer term, this will be governed by formal arrangements under either section 256 or section 75 of the 2006 Act.

Greater Manchester

In November 2014 Chancellor George Osborne and leaders of the Greater Manchester Combined Authority (GMCA) signed an agreement allowing for the devolution of new powers and responsibilities to Greater Manchester and the establishment of a directly elected city-wide mayor. As well as transferring powers over transport, housing, planning and policing, the devolution agreement invited the GMCA and local CCGs to develop a business case for the integration of health and social care.



Building on this, in February 2015 the Association of Greater Manchester Authorities (representing the 10 local authorities in Greater Manchester), the 12 Greater Manchester CCGs and NHS England signed a memorandum of understanding agreeing to bring together the relevant health and social care budgets of each, worth approximately £6 billion in 2015/16, and to work towards the ultimate devolution of all health and care responsibilities to accountable, statutory organisations in Greater Manchester. The memorandum of understanding commits the organisations to a set of principles, and in particular to the development of a comprehensive Greater Manchester strategic sustainability plan for health and social care, aligned with the Forward View.

The memorandum of understanding describes 2015/16 as the ‘build-up year’ during which local organisations will work collaboratively in shadow form before full devolution in April 2016. The new Greater Manchester Strategic Health and Social Care Partnership Board will represent commissioners, providers and NHS England with leadership from a newly appointed chief officer. In 2015/16 the Board will oversee the development of the local health and care economy and steer the development of the Greater Manchester strategic sustainability plan, with the formal process for its establishment complete by April 2016 ([Association of Greater Manchester Authorities 2015](#)).

A Greater Manchester joint commissioning board (JCB) will also be created, comprising local authorities, CCGs and NHS England, with responsibility in 2015/16 for discussing and agreeing recommendations in relation to Greater Manchester’s spend and engaging in decisions affecting health and social care. There will be no immediate change in legal responsibilities, but by April 2016 the joint commissioning board will become a formal board operating under section 75 agreements. Decisions as to the financially accountable body and form of governance will be agreed during 2015/16.

At a local level, this commits local authorities and CCGs to agree a local memorandum of understanding that supports collaborative working, and to build on the Better Care Fund to develop a local plan for the integration of health and social care, to be implemented from April 2016. It is envisaged that once full devolution is achieved (2016/17), health and wellbeing boards will agree strategic priorities for the delivery of integrated health and social care, with the Greater



Manchester Strategic Health and Social Care Partnership Board working to ensure consistency across local areas, and pooled funds being used where relevant.

Although many of the details are still to be developed, the overarching memorandum of understanding suggests that a range of other functions will be delegated to Greater Manchester. In particular, it is to become responsible for designing and creating a provider structure to support its commissioning intentions, and will ‘play a clearly defined leadership role in the oversight of its provider community’ ([Association of Greater Manchester Authorities 2015](#)).

The memorandum of understanding is clear that Greater Manchester NHS will remain within the NHS and be subject to the NHS constitution. It also suggests that the changes described will be achieved entirely through changes to working arrangements, with the statutory functions, accountabilities and financial flows of local authorities and CCGs remaining as they are. However, the details regarding accountability and risk-sharing have still not been finalised, and it is not entirely clear how the new Greater Manchester Strategic Health and Social Care Partnership Board will work with CCGs and local authorities in future. Nonetheless, as far as they have been described, the proposed arrangements, and in particular the plan for NHS England to delegate its relevant commissioning budget, represent the most significant and far-reaching attempt at integrated commissioning in England to date.

Scotland

The Scottish Government has created a completely new legislative framework for integration between health and social care commissioning and delivery – the Public Bodies (Joint Working) (Scotland) Act 2014. This has the aim of providing high-quality care and joined-up services that support people to stay in their homes, and of ensuring resources are used effectively to provide services for the growing population of people with long-term and complex conditions, many of whom are older.

Health boards and local authorities are required to enter into integrated partnership arrangements by April 2016, that will:

- have an **integrated budget** – as a minimum this will cover adult social care, adult community health care, and aspects of adult hospital care



- establish **locality planning arrangements** at sub-partnership level – this is to ensure engagement with local people and key stakeholders
- put in place a **joint strategic commissioning plan** – this will include national and local outcomes.

Scope

The Act requires the integration of all adult social care services, adult community health services and a proportion of adult hospital services (**Scottish Government 2014**). The inclusion of children's services is at the discretion of local organisations. Of the total £12.3 billion health and social care budget in Scotland, a minimum of £7.7 billion (just over 60 per cent) will be delegated to integration authorities.

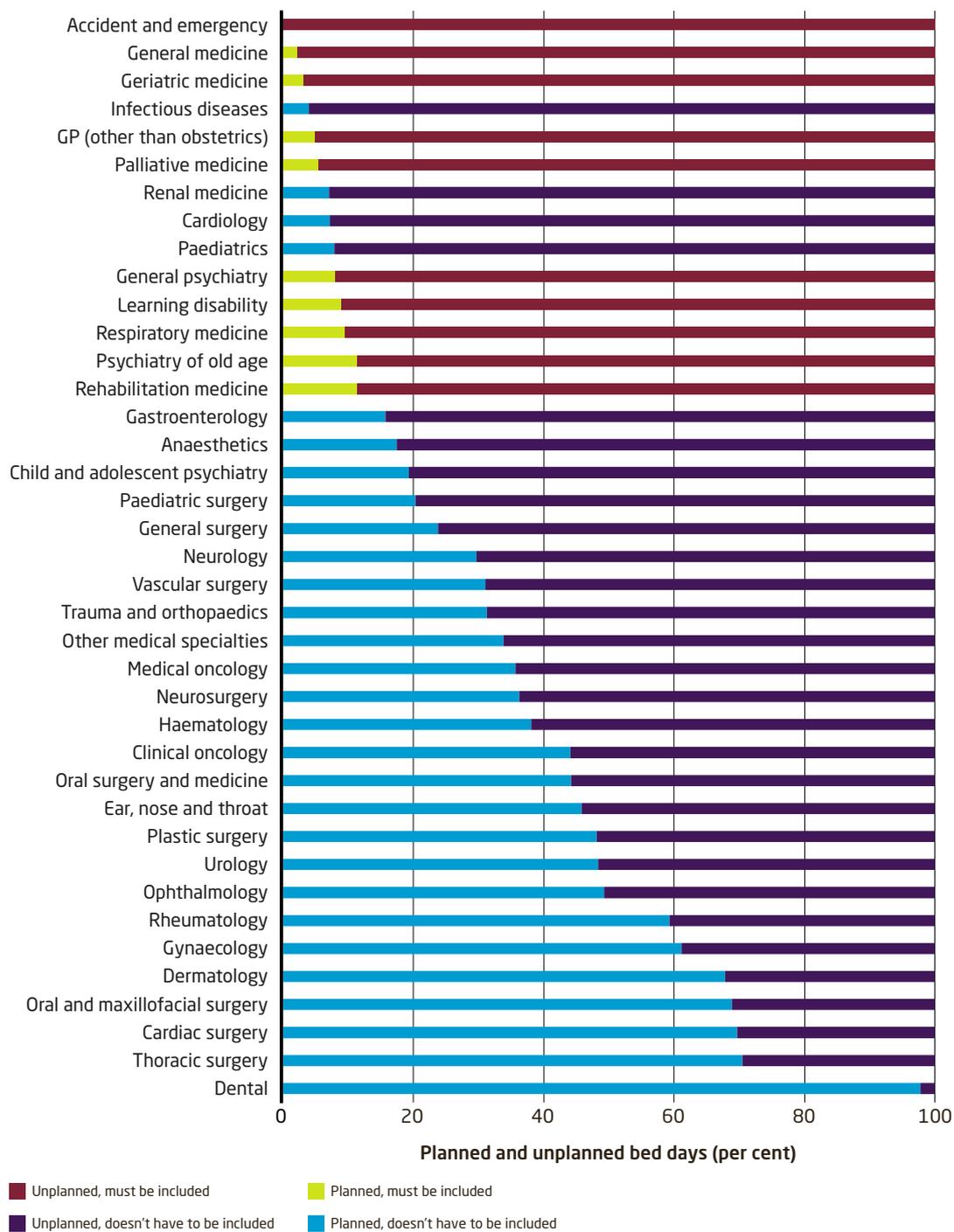
A proportion of hospital services is included to ensure a joined-up service across the pathway. Figure 10 illustrates which hospital services local organisations are obliged to include, and which are discretionary. Services have been allocated largely according to the degree to which they are associated with long-term and complex conditions, and unplanned care.

Integration of some specialties is mandatory (*see* Figure 10). In a number of areas, such as geriatric medicine, planned care is included primarily because it is associated with a significant amount of unplanned activity. Together these services represent one-third of all hospital spending in Scotland, and are associated with 75 per cent of all unplanned bed days, 83 per cent of unplanned bed days for those aged over 75, and 96 per cent of bed use attributable to delayed discharges. Approximately 12,000 beds will be included in the new arrangements.

Some specialties do not have to be included within integrated arrangements, but can be included at the discretion of the health board and local authority.



Figure 10 Hospital services that should be included in local integrated budgets in Scotland





Models

Health boards and local authorities have been provided with two models to choose from when establishing these arrangements. The first model involves the delegation of functions and resources to either the health board or local authority; the second involves the delegation of functions and resources from both local bodies to a new ‘integration joint board’. Each of these models is outlined in more detail below.

Neither model requires staff who deliver services to transfer to a new employer, or to change their terms and conditions.

Model one – lead organisation

Under this model either the health board or local authority acts as the lead agency and takes responsibility for planning, resourcing and delivering the agreed scope of integrated services. Both bodies establish an integration joint monitoring committee to scrutinise delivery arrangements and report on progress.

The chief executive of the lead organisation acts as the single point of management for the integrated budget and service delivery and appoints a strategic planning group to support the development of a strategic (commissioning) plan.

Model two – integration joint board

Under this model the health board or local authority each delegate its functions and resources to a new integration joint board. This is established by secondary legislation, and becomes a legal entity in its own right.

The integration joint board appoints a chief officer and an officer responsible for financial administration (this may be the chief officer or a joint appointment from the senior finance team at either organisation). The integration joint board also establishes a strategic planning group to support the development of a strategic (commissioning) plan.

The chief officer of the integration joint board is directly accountable to the chief executives of the health board and local authority for the delivery of the service and for meeting identified outcomes, set out in secondary legislation. The board re-allocates resources back to the health board or local authority for the delivery of services.



Implementation

To support the implementation of the new arrangements, the Scottish Government has provided transition funding totalling £7 million. In addition, it is allocating more than £500 million over three years to the new partnerships to support delivery of the national outcomes.

In line with the requirements of the Act, the new arrangements began formal operation at the beginning of April 2015, although many areas had been operating shadow arrangements for some time. Integrated arrangements must be in place everywhere by April 2016. The majority of areas have opted for the second model and are establishing new integration joint boards.

Scotland's national health and wellbeing outcomes

As part of the move to implement integrated commissioning arrangements across Scotland, a set of nine outcomes or high-level statements has been developed as a strategic framework for the planning and delivery of health and social care services, supported by an agreed set of indicators. These outcomes are set out in secondary legislation. Newly established integration authorities will be held accountable for delivering these outcomes, and are required to demonstrate their progress in annual performance reports.

Outcome 1: people are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2: people, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 3: people who use health and social care services have positive experiences of those services, and have their dignity respected.

Outcome 4: health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5: health and social care services contribute to reducing health inequalities.

continued on next page



Scotland's national health and wellbeing outcomes *continued*

Outcome 6: people who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

Outcome 7: people using health and social care services are safe from harm.

Outcome 8: people who work in health and social care services feel engaged with the work they do and are supported to improve continuously the information, support, care and treatment they provide.

Outcome 9: resources are used effectively and efficiently in the provision of health and social care services.



7 Options for integrated commissioning

Should health and wellbeing boards be the single commissioner?

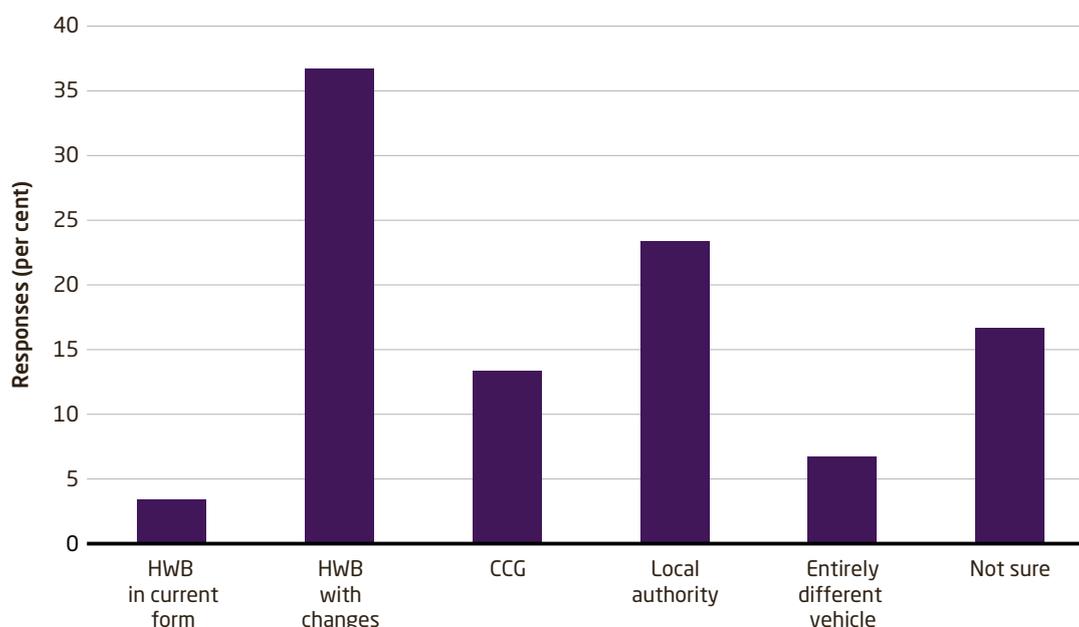
It is not surprising that many see health and wellbeing boards as the obvious candidate to take on the role of a single commissioner. After all they were established to promote integration and take a strategic view of the health and care needs of their local population. As we have noted, a range of voices from members of the Health Select Committee to the Shadow Secretary of State for Health have called for health and wellbeing boards to be given a stronger role in overseeing the commissioning of the whole spectrum of health and care services. The Local Government Association and the Association of Directors of Social Services have endorsed this, with the latter arguing that they ‘offer the best prospects of crafting local solutions tailored to local needs and circumstances’ ([Association of Directors of Adult Social Services 2015](#)). There is significant cross-party support for a stronger role for health and wellbeing boards (see box on party positions earlier in this paper). They have become the latest poster boy for partnership working. Giving them the role of single commissioner has the advantage of building on an organisational vehicle that already exists and might accelerate the evolutionary development of local relationships.

One of the specific objectives of The King’s Fund’s survey was to gather views on who should perform the role of a single commissioner, if this recommendation by the Barker Commission were to be taken forward.

Of the options provided, overall the ‘health and wellbeing board, with changes’ attracted the most support (37 per cent), although only 3 per cent considered it to be the appropriate vehicle in its current form. The next most popular choice overall was the local authority, with nearly a quarter (23 per cent) identifying this as the body best suited to carrying out the single commissioner role (Figure 11). (Note: 30 out of 31 respondents in the sample completed this set of questions.)



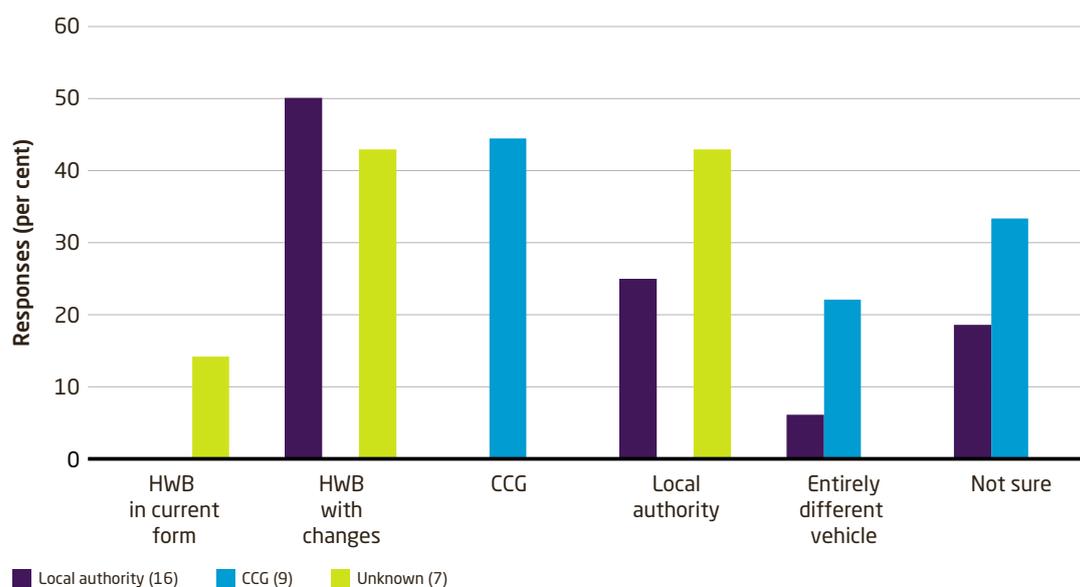
Figure 11 Who should carry out the role of a single local commissioner?



However, a breakdown of the results by organisation type reveals a striking difference in local authority and CCG perspectives: while 50 per cent of local authorities selected the health and wellbeing board with changes as the most appropriate single commissioner, none of the CCGs chose this option. Conversely, 44 per cent of the CCGs responding to the question identified the CCG as the right body to take on the single commissioner role, although none of the local authorities answered in this way (Figure 12). A survey undertaken by London Councils found that CCGs were more likely to express frustration at health and wellbeing boards' lack of decision-making powers and the constraints arising from their status as a statutory committee of local authorities. Enthusiasm for their potential in taking on a bigger role is less marked among NHS partners ([London Councils 2015](#)). A national survey based on responses from 80 CCGs revealed considerable nervousness about health and wellbeing boards playing a bigger role in health commissioning, especially if this meant that the CCGs' role became purely advisory (Welikala and West 2015). In one regional survey, none of the local authority respondents thought that health and wellbeing boards should be the single commissioner; the majority favoured them with changes, or a new vehicle entirely (Improvement and Efficiency West Midlands, forthcoming).



Figure 12 Who should carry out the role of a single local commissioner (responses by organisation type)

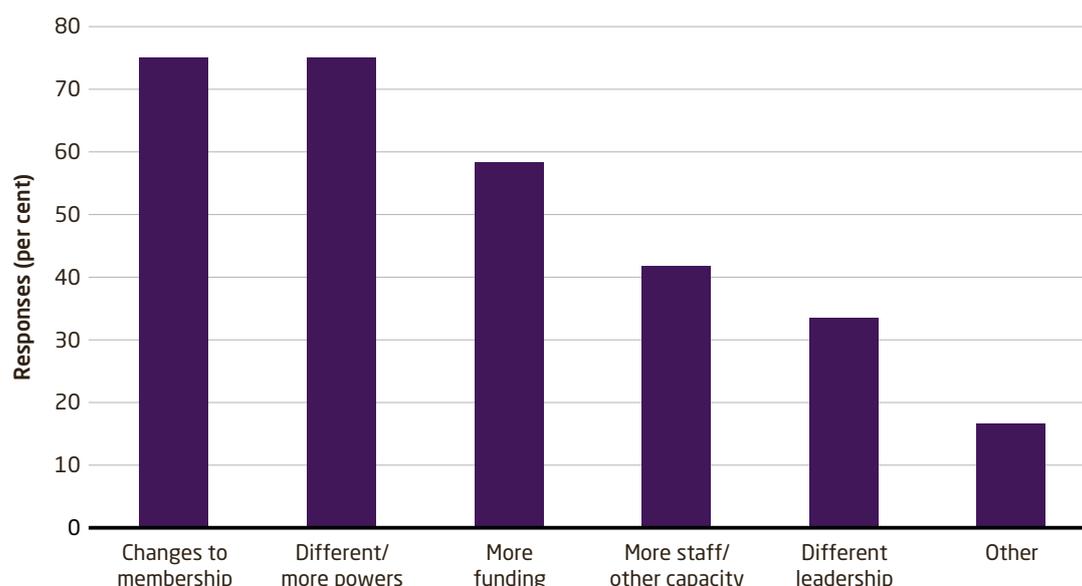


This suggests that far more work would be needed to build the confidence that NHS organisations have in the potential of health and wellbeing boards to become a single commissioner.

The difference in levels of support for the ‘health and wellbeing board in its current form’ as a single commissioner (the least popular option) compared with the ‘health and wellbeing board, with changes’ (the most popular option) suggests that while many local organisations consider health and wellbeing boards have the potential to take on a greater role in commissioning, they are clear that these do not yet have the skills and resources required. When asked what changes would be required in order for them to become the appropriate body, the most popular answers were ‘changes to the membership’ and ‘additional or different powers’ (each cited by 75 per cent of respondents answering the question), followed by ‘more funding’, which was selected by 58 per cent of respondents (Figure 13). In addition, a number of the free-text responses emphasised the scale of change required and the impact this might have not only on the health and wellbeing board, but on other local organisations and, potentially, NHS England.



Figure 13 If health and wellbeing board with changes is appropriate, what changes are required?



Taking on responsibility for all health and social care commissioning would be a seismic shift for health and wellbeing boards, with profound implications for their size, composition, legal duties and powers. They would need substantial new capacity and expertise to address effectively the complexity of many aspects of health care commissioning. Although there is evidence that many are making reasonable progress in promoting local collaboration and partnerships, few appear to have stepped up to provide a system leadership role and few can demonstrate readiness to take on an executive decision-making role over an integrated local budget or command the confidence of their CCG partners. For these reasons we do not consider that in their current guise health and wellbeing boards are fit for purpose throughout the country to take on the role of single local commissioner.

From our assessment of existing arrangements and emerging developments in different parts of the United Kingdom, three broad options emerge for how a single commissioning function, with a single integrated budget, could be developed. These are set out below.



Option 1 – build on existing organisational and policy arrangements

This option would involve no significant nationally imposed changes to current structures, working instead with the grain of existing organisations and policy processes. Health and social care funding would continue to be routed separately to CCGs and local authorities with an expectation that they reach local agreement on how their separate funding streams should be aligned around agreed local priorities and needs, and how services should be commissioned, and by whom.

This option would be the least disruptive in terms of organisational change, allowing organisations to continue using existing mechanisms such as pooled budgets and lead commissioning arrangements (as set out in Appendix 2) to promote better integration of care. This approach would build on local relationships that are already being developed through the Better Care Fund planning process. It would be for CCGs and the local authority to agree whether their health and wellbeing board is ready and able to take on a formal decision-making role in respect of commissioning decisions. This option would be consistent with other policy initiatives such as the Integrated Care and Support Pioneers Programme and the emerging Forward View vanguard programme. National accountabilities would remain unchanged although local bodies would need to agree joint accountability arrangements for pooled budgets.

This approach emphasises the importance of local partnerships and could work in places with strong and effective working relationships and a shared vision of what they want to achieve – for example, Sheffield, Southend, Devon and Plymouth are beginning to move in this direction on a voluntary basis. Faster progress could be stimulated by introducing stronger incentives and signals from the centre. For example, the Better Care Fund could be expanded so that the percentage of NHS and social care spending brought within the pooled budget is progressively increased year on year. A new requirement could be introduced for local authorities and NHS partners to co-operate and reach agreement on the size of the local integrated budget, the scope of services or needs it covered, and who was responsible for commissioning which services.

However, this approach is unlikely to work everywhere, for example, in places where efforts to achieve integrated care have been undermined by a history of poor relationships and severe financial or performance challenge. As we have seen, despite a range of mechanisms being available to local organisations, progress in



developing effective joint commissioning arrangements has been limited and patchy. Places with ambitions to develop single commissioning with a pooled budget across a wide range of services are few and far between, suggesting there may be wider issues at play, including cultural and behavioural factors. This option perpetuates the fragmentation and fractures between local commissioning bodies that are widely felt to be a significant cause of the poorly co-ordinated and fragmented care that many people still receive. Given this, it seems doubtful that relying on local efforts and commitment alone will achieve the scale and pace of change that is required to establish a single commissioning process based on an integrated budget across the whole country.

Option 2 – CCG or local government to take responsibility

Another option is to assign lead responsibility for commissioning either to local government – so that local authorities would become responsible for all health and social care commissioning – or to CCGs. A clear advantage of this approach is that, unlike current arrangements which support a variety of joint commissioning arrangements, often determined on a service-by-service basis, there would be a single and unambiguous local body with clear responsibility and accountability for the entire integrated budget.

The debate about whether local government should be given responsibility for health commissioning has raged off and on for years, originating in the decision to create a new National Health Service in 1948 rather than give this role to local authorities. Over the years a wide range of arguments has been deployed for and against such a switch, for example, the advantages of increasing democratic input into decisions about local health services, or the difficulty of preserving local government autonomy were it responsible for delivering the priorities of a more centrally led health system (Glasby *et al* 2010). The converse option of giving the lead role to CCGs would be seen by many as a substantial erosion of democratic legitimacy and would almost certainly require new primary legislation. It would remove from local government a big element of its current critical mass, in terms of resource and funding, and could trigger a battle for control between local government and the NHS at a time when their energies should instead be focused on collaboration over addressing shared challenges. This would set back progress and damage local relationships on which progress depends. It would also involve major organisational change.



There are some circumstances where this option might be right – notably in places where there is a strong history of mature relationships between the local authority and NHS commissioners. North East Lincolnshire CCG, for example, has commissioned adult social care as well as health services since 2007, building on the achievements of the previous care trust. But to prescribe this solution for all places would be fraught with challenges for the reasons discussed.

A different way of implementing this option would be to emulate the Scottish approach and require local authorities and CCGs to agree between themselves which organisation should be the single commissioner. This avoids a prescriptive one-size-fits-all approach but demands a high level of maturity from local organisations in order to reach agreement. It would almost certainly involve major organisational change at the local level and result in a mixture of arrangements across the country with either the NHS or local government being the accountable organisation. This would raise further issues of public and political accountability given the fundamentally different governance arrangements for CCGs and local authorities.

Option 3 – a new vehicle: ‘health and wellbeing boards plus’?

A third option is to establish a completely new local vehicle to be the single commissioner. This could appear to involve the most extensive organisational change of all as it would leave no role for either local authorities or CCGs. However, there is an evolutionary option that would not involve a complete upheaval of existing organisations but which would build on them – this is to revamp the role of health and wellbeing boards.

We have concluded that in their current guise, health and wellbeing boards are not fit for purpose to become the single commissioner. But there is no reason why, over time, they could not be re-cast as the local executive decision-making body for the integrated budget – with a rebalanced membership drawn from CCGs and local authorities, fresh powers and duties, and supported by a single commissioning function that draws on the capacity and expertise from both the CCG and local authority. In this sense the new boards could resemble a local version of the Strategic Health and Social Care Partnership Board proposed in Greater Manchester or the joint integration boards created in Scotland through the Public Bodies (Joint Working) (Scotland) Act 2014. There would be a continuing role for CCGs which would in effect share sovereignty with the local authority by delegating their



responsibilities to the new board rather than becoming an advisory body as has been suggested in some quarters.

This would minimise organisational change but is likely to require primary legislation to ensure that the board has adequate legal powers. This would take time but would allow existing boards to accelerate the pace of their development and capacity in the meantime. It would also require the development of a governance model that ensures the engagement of providers without compromising the essentially commissioning role of the new board, as Greater Manchester is proposing.

At such an early stage in their development this would be a profound step-change in the role and responsibilities of existing boards. Confidence that each board was up to this challenge could be assured through a robust capability assessment similar to the CCG assurance process. This could be developed and applied by NHS England and the Local Government Association.



8 Conclusions

The case for change in commissioning health and social care services is overwhelming. If we were starting afresh no one would design a system with approaching 400 separate local organisations each responsible for commissioning different kinds of service. The current fragmentation of the organisational landscape is not sustainable.

The primary challenge now facing the NHS and local government is how to manage intensifying financial and service pressures while shifting to more integrated models of care that better reflect 21st century needs. The key question is whether it is possible to move towards single local commissioning arrangements without plunging services into a distracting and disruptive structural reorganisation.

The starting point should be to focus on the outcomes that well-designed integrated care should aim to achieve everywhere through a single, nationally agreed outcomes framework. A mandatory requirement should then be placed on all local authorities and CCGs to demonstrate how, by the end of the next parliament, those outcomes would be achieved locally through a single commissioning function for their local population. This should be expressed in a local integration programme that sets out a timetable to move towards a single integrated budget which should include, as a minimum, spending on adult social care, community health, public health, primary care and mental health services and defined acute services (which should be determined on a service-by-service basis in a similar way to the Scottish approach described earlier).

Recognising that there is no one-size-fits-all solution, the organisational model by which this is achieved should be developed and agreed locally from 2017, drawing on the options set out in this paper. Many places will be able to make faster progress than others but the aim should be that by 2020 at the very latest there will be a single local commissioning function, with a single integrated budget, in place in all parts of the country.



This should be guided by a set of explicit principles to help the design of a single local commissioning process for every part of the country.

- Change will be guided by agreement between CCGs and local authorities about what arrangements will work best locally – there should be no large-scale top-down reorganisation imposed from the centre.
- The role of the centre is to set a clear policy framework that describes the outcomes of single commissioning but does not prescribe how they should be achieved locally. It could support the development of local arrangements by:
 - establishing a single outcomes framework that describes the ends (but not the means) that every local single commissioning arrangement should achieve; the Scottish Government, for example, requires local integration boards to publish an annual performance report setting out how well they are delivering integrated care against prescribed outcomes ([Scottish Government 2015](#))
 - offering potential organisational templates for single commissioning, including governance and accountability arrangements, that local systems can consider, such as the options described in this paper; it will be necessary to consider changes required through primary or secondary legislation to create the ‘health and wellbeing board plus’ option
 - considering complementary changes to the regulatory and policy regime that would allow the oversight of how well each local whole system (as opposed to individual organisations) are meeting individual and population needs; and allow local freedom to experiment with different contracting and payment mechanisms
 - taking steps – through legislation or statutory guidance – to remove legal obstacles to the full transfer of budgets and responsibilities across organisational boundaries so that local bodies can consider a range of organisational options.
- Each local integration programme should be consistent with parallel changes in the provider landscape, for example in the Forward View vanguard sites, and incorporate existing work under way across integration pioneer sites. The Better Care Fund planning arrangements could be subsumed into the local integration plan, so there is one single, shared vision for integrated care and a plan for implementing it.



- In view of the intense financial pressures, local programmes should be required to demonstrate that the changes add value rather than cost to the commissioning of local services, with an expectation that simplification of current arrangements ought to generate financial savings.
- The local change process should demonstrate how the public and people who use health and care services will be engaged in considering local options.

It is important to recognise that a single commissioning function based on a single local budget will not of itself be sufficient to overcome the fault lines in national policy and funding identified by the Barker Commission.

The need to secure adequate sustainable funding of both health and social care – facing a combined funding gap of at least £12 billion by 2020 – underlines the need for central government to act to establish a single combined spending review process and settlement for the NHS, social care and public health. The parameters of this would need to be defined, but at the very least they would need to cover most local authorities' commissioning budgets for adult social care and a significant proportion of CCGs' budgets for acute, community and mental health services. The allocation of funding to local authorities by the Department for Communities and Local Government would no longer be necessary. The Department of Health would instead become the primary department of state responsible for negotiating and agreeing the settlement for the single integrated budget and allocating it to local areas.

There are also major implications for how NHS funding is routed to local areas. Currently public funding for local health services is allocated by central government to NHS England based on its mandate from the Secretary of State and the NHS constitution. NHS England then allocates resources to local CCGs for the commissioning of acute hospital, community and mental health services – but not for primary care and specialised services, which are commissioned by NHS England itself. NHS England has already begun to give many CCGs a stronger role in commissioning primary care services. It will be necessary to determine which of these services are included in the coverage of the single integrated budget – although there are strong arguments for including primary care as a minimum – and what role NHS England should play in future in commissioning specialised services.



A further consideration is where the scale of the commissioning challenge exceeds the geographical footprint of the single local commissioner. The future development of hospital services, especially in densely populated conurbations, is the obvious example where local commissioners would need to work together. The commissioning of specialised services is another. The Greater Manchester proposals offer one route for strategic joint commissioning across a number of local systems, with the single commissioner role taking place at local authority/CCG level.

There are organisational complexities within local systems that also need to be considered carefully, for example, in county council areas where there are several CCGs.

Detailed work would be needed to assess ways of allocating the single integrated budget, either through a combination of existing NHS England and Department for Communities and Local Government allocation formulae or by moving over time towards a completely different formula. For the foreseeable future, the aim should be to ensure stability in the overall allocation of resources and avoid sudden changes in the amount that particular areas receive.

Establishing a single integrated national health and care budget stream would be an important and essential simplification of responsibilities within central government. It would remove the existing split between the Department for Communities and Local Government and the Department of Health; it would ensure that one department rather than two was responsible for negotiating and implementing the spending review settlement; and it would establish a single line of sight and accountability (in terms of funding) between central government and local areas. The King's Fund intends to carry out further work on how a permissive regime that enables local organisations to achieve better outcomes for people is supported by clear national accountabilities to the centre.

At a later stage, consideration could be given to extending the single commissioning pot to include other public service budgets such as housing-related spending and certain welfare benefits such as attendance allowance. In this way the establishment of a single budget for health and care could be a staging post towards full place-based public service budgets throughout the country.



Forty years of successive attempts to achieve closer alignment of health and social care resources – let alone their complete integration – should leave us under no illusion about how difficult this is. More of the same will not achieve change on the scale and at the pace required (Ham 2014). But with local government, the NHS and all political parties committed to the goals of integrated care and the election of the new government, there has never been a better time for taking bold steps to make it happen.



9 Recommendations

- A single national outcomes framework for integrated care should be agreed to ensure there is joint accountability between the NHS and local government.
- CCGs and local authorities should be required to produce and agree a local integration programme that sets out how they will achieve these outcomes locally through a single commissioning function and a single integrated budget covering, at a minimum, spending on adult social care, community health, primary care, mental health services, public health and defined acute services.
- The organisational and governance model by which this is achieved should be developed and agreed locally, drawing on the options set out in this paper. From 2017, local authorities and NHS partners should establish a single local commissioning function, with a single integrated budget. This should be in place everywhere by 2020 at the very latest.
- Every local integration programme should incorporate the existing Better Care Fund planning process and reflect existing work by vanguards and pioneers – so there is one single, shared vision for integrated care, one plan for implementing it and one set of support and oversight arrangements.
- The Department of Health and NHS England, with the Local Government Association, should agree a set of principles to guide the design of local arrangements, specify the conditions that local agreements must meet – including governance, accountability and outcomes to be achieved; and consider a formal authorisation process for the local commissioning body.
- National bodies should work with CCGs and local authorities to develop organisational templates, based on the options in this report, on which local arrangements can be based. This should include consideration of primary and secondary legislation to make possible the ‘health and wellbeing board plus’ option and the removal of any other legal or policy obstacles to a single local commissioner.

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- The government should introduce a single spending review settlement covering the NHS, social care and public health; simplify departmental responsibilities by transferring social care funding from the Department for Communities and Local Government to the Department of Health; agree funding streams and formulae to allocate resources towards local areas; and consider how current spending on attendance allowance could be brought within the local integrated budget without reducing future entitlements.



Appendix 1: A note on The King's Fund's joint commissioning survey

As indicated above, there are different views as to which (if any) of the above models is the most appropriate mechanism for taking integrated commissioning forward. To understand different views on this issue at a local level, The King's Fund carried out a survey of local authorities and CCGs.

The specific objectives of the survey were to understand views on:

- the extent to which local authorities and NHS partners are sharing commissioning resources and roles, and what these arrangements cover
- how well current arrangements are working
- health and wellbeing boards' readiness for taking on the role of single commissioner
- other vehicles that would be appropriate for this role.

Approach and response rate

The survey was targeted at local authorities and CCGs across England over a period of approximately three weeks between December 2014 and January 2015. The survey consisted of 20 questions, most of which were multiple choice, and many of which gave respondents the opportunity to include additional comments.

A total of 31 surveys were completed, representing 33 organisations due to two joint responses. Of the 33 organisations involved, 16 were local authorities, 9 were CCGs and 8 chose not to specify. Throughout the report, where we discuss respondents, this includes the jointly completed surveys as a single respondent. However, where we discuss organisations, all 33 organisations are counted individually.

Not all respondents/organisations answered all the survey questions. The percentages quoted in the text and shown in the graphs refer to the proportion of responses to



that particular question. Some questions allowed multiple answers, and therefore the bars in the graphs may add up to more than 100 per cent.

Unfortunately, these figures represent a very low response rate, constituting less than 10 per cent of the total number of CCGs and local authorities.

In light of this, it is important to bear in mind that all of the findings set out below are drawn from a very small sample and that they represent the views of those organisations that chose to respond, rather than a random sample. Not all respondents answered all questions, and therefore in some cases the sample size is less than 31.

Nonetheless the results offer an interesting insight into CCGs and local authorities' assessment of current arrangements, and into views on how these might feature in integrated commissioning arrangements in future. As we have noted, many of the responses are consistent with the findings of other surveys.



Appendix 2: Mechanisms for joint commissioning

Defining 'joint commissioning'

Joint commissioning can be broadly understood as the coming together of organisations in the form of a 'partnership, alliance or other collaboration' to take joint responsibility for commissioning a set of services (Glasby 2012). This can involve organisations working in partnership at all stages of the commissioning process, from the assessment of needs, to the planning and procuring of services, and the monitoring of outcomes.

On the basis of a review of five case study sites, Glasby and colleagues also noted that, although arrangements vary significantly, it is possible to identify a set of features common to joint commissioning (Glasby *et al* 2013).

- **Formalised structures** – in many cases joint commissioning has been facilitated by formalised arrangements, such as integrated organisations or integrated management teams. These arrangements are often set down in writing to protect against changes in personnel or political priorities.
- **Pooled budgets** – one feature common to almost all joint commissioning arrangements is the use of a shared budget (using one of the flexibilities described below). Often the budget is associated with a particular population or disease group with needs that span the responsibilities of both organisations.
- **Lead commissioning arrangements** – lead commissioning arrangements (described in more detail below) are often linked to pooled budgets, with one partner taking the lead on commissioning a particular service in order to avoid duplication.
- **Co-location** – joint commissioning often involves the co-location of the relevant staff from each organisation.



- **Hybrid roles** – joint commissioning can involve the appointment of staff who span more than one organisation, often at senior manager level.
- **Integrated/streamlined needs assessments** – joint commissioning arrangements typically involve a single needs assessment process. Within the current system, health and wellbeing boards are responsible for producing a joint strategic needs assessment and a joint health and wellbeing strategy that meet the current and future needs of the local population. They are also required to consider using NHS Act 2006 flexibilities, such as pooled budgets, in order to meet these needs.

A number of these features are linked to specific operational and legal mechanisms, some of which are described below.

Integrated and lead commissioning arrangements

Section 75 of the NHS Act 2006 gave PCTs and local authorities legal powers to enter into integrated and lead commissioner arrangements (originally set out in the Health Act 1999).

Where lead commissioning arrangements are in place, commissioning duties are delegated between organisations, and one organisation leads on behalf of the other(s) to achieve a jointly agreed set of aims. The lead commissioner is responsible for commissioning the agreed scope of services, within the relevant budget, and for entering into contracts with providers.

Governance of integrated or lead commissioning arrangements are typically set out in a section 75 agreement (along with arrangements for pooled budgets, as below).

Aligned budgets

Health and social care commissioners have the option of aligning budgets for an agreed service area. Where budgets are aligned, information is shared between the organisations, and priorities and strategies may be agreed jointly. However, management of the individual budgets, monitoring and reporting all remain separate.



In the past, difficulties with the accounting rules surrounding pooled budgets (see below) has meant that some organisations have chosen to align rather than pool their budgets ([Audit Commission 2009](#)). However, the former is often used as an interim step to pooling.

Pooled budgets

Section 75 of the NHS Act 2006 (originally introduced as section 31 of the 1999 Act) enables local authorities and NHS bodies to create pooled budgets using contributions from their individual allocations. Where a pooled fund is established, the participating organisations typically enter into a signed section 75 agreement which sets out: the aims and desired outcomes for the fund; the NHS and local authority functions that are included; details of the host; the approach to management and monitoring; governance arrangements; the client group(s) covered; and participants' respective financial contributions.

A major attraction of pooling budgets to jointly commission services is the flexibility it offers in the use of funding. Pooling budgets can also help to focus commissioners on the achievement of joint outcomes, preventing them from becoming too distracted by where costs will fall.

However, section 75 does not allow for all health and social care services to be included within a joint fund. For example, NHS organisations are prevented from delegating the commissioning of surgery, radiotherapy or ambulance services, and while local authorities can delegate a broad range of their services, the legislation sets out some detailed exclusions ([Healthcare Financial Management Association 2014](#)).

Where a pooled budget is in place, one partner is required to act as the host and becomes responsible for the budget's accounts and audits, as well as for paying suppliers. This should mean that transactional costs and bureaucracy are lower than they would have been were the services commissioned from two (or more) separate budgets. However, the creation of a pooled budget does not constitute a delegation of statutory responsibilities, which are retained by the individual CCG and local authority. Each must ensure that the relevant regulatory requirements relating to their funding streams are met and consider the regulatory impact of decisions made.



The decision as to which partner will host the fund is determined locally. Precise governance and operational arrangements for pooled funds also tend to vary locally. Depending on the size of the pooled budget, this may involve the establishment of a joint management group comprising representatives from each of the organisations involved.

Section 75 agreements are the basis for the Better Care Fund, which brings a number of existing funding streams together into a pooled budget. As with all pooled funds, the Better Care Fund will operate as a single budget, but conditions attached to each of the component funding streams will still have to be met. Arrangements for operating the Better Care Fund will also have to meet the governance and regulatory requirements of the individual participants ([Healthcare Financial Management Association 2014](#)).

Transfer payments

Sections 76 and 256 of the 2006 Act respectively allow local authorities to make revenue or capital contributions to health bodies to support specific services, and vice versa. These powers also apply at a national level, enabling the Department of Health to transfer funding to local authorities.

As in the context of pooled budgets, a contribution is made to support a specific service, but does not involve the delegation of functions from either the CCG or local authority.



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The fact that health and social care services are currently commissioned separately is a major obstacle to the development of integrated care. Support is growing for a new settlement based on a single ring-fenced budget and a single local commissioner – as recommended by the independent Commission on the Future of Health and Social Care in England, chaired by Kate Barker.

The King's Fund builds on this central recommendation in *Options for integrated commissioning*. It assesses evidence of past joint commissioning attempts, studies the current policy framework and local innovations in integrated budgets and commissioning, and considers which organisation is best place to take on the role of single local commissioner.

Based on a survey of existing joint arrangements, a seminar with pioneers of integration developments, and a national conference on integrated commissioning, the authors found that:

- examples of fully integrated commissioning are limited and their effectiveness varies significantly
- local authorities were overall more positive about health and wellbeing boards' potential than NHS partners
- few boards seem ready to provide a system leadership role or command the confidence of CCG partners
- in their current guise, most health and wellbeing boards are not ready to take on the role of single local commissioner.

A strong message from this work is that integration is not an end in itself but a means to better outcomes. With this in mind, the authors present a set of steps and recommendations to ensure that there is a single local commissioning function, with a single integrated budget, in all parts of the country by 2020.

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