

Exploring Strategic Commissioning Models – A discussion paper

Stephanie Carson

Pauline Fox

Anna Gaughan

Peter Lacey

January 2010



Facilitating transformation



Contents

1. Introduction	1
1.1 Background	1
1.2 Purpose of this paper and intended audience	1
2. Developing a common ‘shared’ understanding of ‘Commissioning’	2
2.1 Multi-layered Commissioning	3
3. Assessment tools for partnership working	8
3.1 Integrated Care Network Grid	9
3.2 Integrated Care Network Questions	9
3.3 Integrated Care Network - ‘From the Ground Up’	10
3.4 Audit Commission – Means to an End	11
3.5 Institute of Public Care	11
4. Learning lessons from other economies	12
4.1 Deep Partnership	12
4.1.1 How it works in practice	12
4.1.2 Challenges faced	13
4.1.3 Lessons learnt	13
4.2 Care Trust Plus (CTP)	14
4.2.1 How it works in practice	14
4.2.2 Challenges faced	14
4.2.3 Lessons Learnt	15
4.3 Care Trust	15
4.3.1 How it works in practice	15
4.4 Summary of lessons learnt	16
5. Conclusion	17

Summary

The target audience for this discussion paper is those strategic leaders who are seeking to further develop their local 'integrated commissioning' approach. It offers the opportunity to consider current policy context and local '*readiness for change*' in the light of the dynamic national environment and in particular:

- Further define and describe what is meant by 'commissioning' and in particular the requirements of commissioning at different levels (multi – layered approach to commissioning) in the context of personalisation and more self directed support (SDS);
- Clarify the distinctiveness between '*joint*' and '*integrated*' commissioning models and explore the push towards and more '*integrated*' models of commissioning;
- Provide some evidence based 'tools' / 'frameworks' with which to undertake a 'self assessment' crucially to enable them to begin to identify what is required to enable them to move more rapidly towards developing an '*integrated* commissioning' function;
- Provide examples, commentary and lessons learnt from other economies who have adopted a more 'transformational' approach to 'integrated commissioning';
- Begin the process to identify a system wide organisational developmental (OD) approach to achieving their ambition of 'integrated commissioning'.

This discussion paper signals that the national agenda is pushing for more formal and fuller integration across local authority and NHS commissioners and against this context, sets out the potential limitations and risks associated with the incremental approach in moving towards 'joint' commissioning on a 'care group' basis.

It highlights the importance of achieving clarity on the local terminology associated with 'joint' and 'integrated' commissioning models and draws out the competencies and architecture required at all levels to support a 'multi-layered' model of integrated commissioning which is required if local commissioning (at all levels) is to be contemporary and 'fit for purpose' in the context of delivering personalisation and self directed support.

It provides a number of assessment tools and frameworks that can be used to undertake a 'self assessment' and generate honest conversations across the extent to which partnership working currently operates and to assess the feasibility of future ambitions of integrated working. From the learning across other economies, there is recognition of the significant challenges facing organisations in achieving integrated commissioning when there has been a history of effective partnership working.

Where there is local intent to develop a more integrated approach to commissioning, in the context of challenging local circumstances, the local strategic leaders will need to draw on each others' strengths, work in a collaborative way, ensure that there is clarity on the 'destination' for integrated commissioning and develop the leadership, capacity and capability within commissioning.

If the locally agreed direction of travel / destination is integrated commissioning, a local action plan might be jointly developed to achieve this goal, including, for example:

1. Undertake a re-appraisal of the current 'position' on partnership working from the perspective of each partner organisation in the light of the NHS World Class Commissioning Programme and the Local Authorities 'Transformation' Programme using one of the suggested assessment tools for commissioning alongside a relational health audit methodology;
2. Undertake a robust transparent 'option appraisal' (including benefits and risks) which will enable each partner organisation to re-state, with sufficient detail and ownership, the nature and level of integrated, coalition based commissioning they are agreeing to at a local level;
3. In the event of a decision to move forward with fuller integration a commitment is required to a 'system wide' organisational development approach to creating the necessary leadership, competencies, capacity and capability within the joint commissioning unit beyond that which is currently available;
4. A commitment to establishing a 'genuine' system –wide sustainable engagement process that is multi- professional and across all levels of the partner organisations.

1. Introduction

1.1 Background

There are clear signals that the national agenda is pushing for fuller integration of commissioning and delivery of services through a variety of policy drivers including efficiency and value for money (VfM), the Place agenda, and personalisation¹. Given the incremental approach adopted by many local partners to move incrementally towards joint commissioning, there is a risk that the focus will once again remain on ‘structural change’ (at the margins) within the respective commissioning organisations without a clear strategic focus on their ultimate ambition of developing a sustainable ‘integrated commissioning’ solution.

In the context of ever challenging circumstances, partners will need to draw on each other’s strengths, work in a collaborative way, ensure that there is clarity on the ‘destination’ for integrated commissioning and develop the leadership, capacity and capability within commissioning to ‘punch above its weight’.

1.2 Purpose of this paper and intended audience

The target audience for this discussion paper is those ‘strategic leaders’ who are seeking to develop their local commissioning effectiveness including, for example, health and well being partnership members. It offers the opportunity to look critically at the local situation and to consider ‘*readiness for change*’ in the light of the dynamic national environment and in particular:

- Further define and describe what is meant locally by ‘commissioning’ and in particular the requirements of commissioning at different levels (multi – layered approach to commissioning) in the context of personalisation and more self directed support (SDS);
- Clarify the distinctiveness between ‘*joint*’ and ‘*integrated*’ commissioning models and explore the push towards and more ‘*integrated*’ models of commissioning;
- Provide some evidence based ‘tools’ / ‘frameworks’ with which to undertake a ‘self assessment’ crucially to enable them to begin to identify what is required to enable them to move towards developing an ‘*integrated*’ commissioning’ function;
- Provide examples, commentary and lessons learnt from other economies who have adopted a more ‘transformational’ approach to ‘integrated commissioning’;
- Begin the process to identify a system wide organisational developmental (OD) approach to achieving their ambition of ‘integrated commissioning’.

¹ Hudson B. (2009) Integrated Commissioning The Missing Link? (November)

2. Developing a common ‘shared’ understanding of ‘Commissioning’

Enhancing commissioning has been the focus of many government publications over the past few years including: ‘Our Health, Our Care, Our Say’², ‘Putting People First’³, ‘Strong and Prosperous Communities’⁴, ‘The Health Act’, the Gershon⁵ efficiency review and more recently the ‘Commissioning Framework for World Class Commissioning’⁶ and the NHS Operating Framework for England⁷

The vision for world class commissioning in the NHS states that, ‘*Commissioning is essentially transformational and not just transactional*’. Commissioning is about developing and shaping the capacity within communities, markets and individual lives that will support all citizens to meet their needs and aspirations regardless of age or disability. It relies on the development of strong relationships and partnership working that requires investment in making explicit the common purpose of an integrated commissioning approach together with the nature and extent of joint working, for example whether and to what extent an integrated commissioning team operates in a virtual or real way.

In March 2007 a Commissioning Framework for health and well-being was published by the Department of Health⁸. This framework looked at commissioning from the perspective of a whole health and care economy and within a context of reforming the systems to meet the needs of individuals. In essence it is a strategic planning approach that aims

- to place people at the centre of our thinking on commissioning
- to understand the needs of populations as well as individuals
- share and make better use of information
- assure quality in provision
- promote wellbeing amongst workforces
- improve partnership working and increase use of flexibilities and pooled budgets
- create a single health and social care vision
- improve capability and leadership

² DH (2006) Our Health, Our Care, Our Say

³ DH (2007) Putting people first: a shared vision and commitment to the transformation of adult social care

⁴ Department of Communities and Local Government (2006) Strong and prosperous communities – the Local Government White Paper

⁵ HM Treasury (2004) Releasing resources for the frontline: Independent Review of Public Sector Efficiency

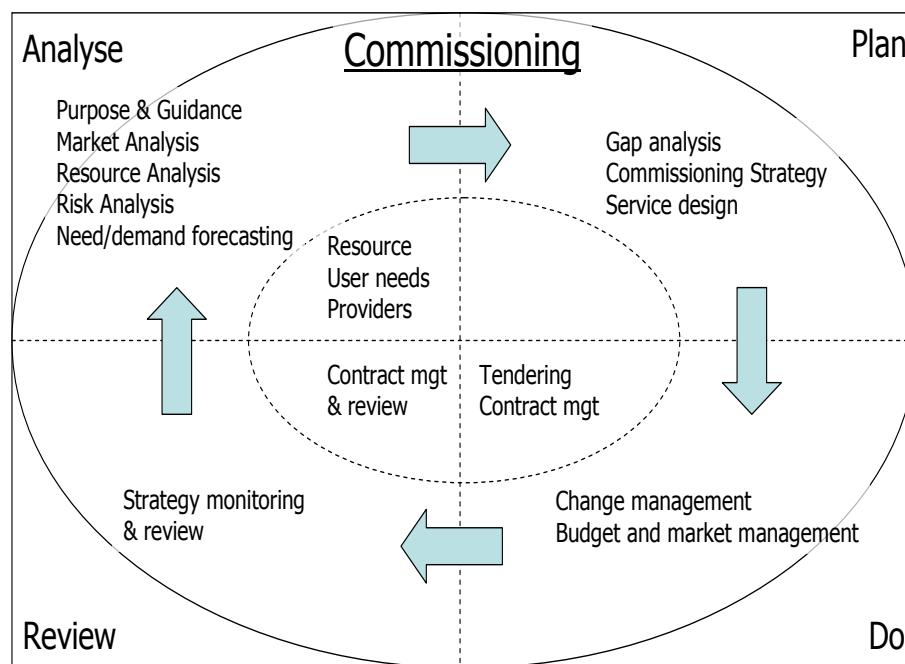
⁶ DH (2007) ‘A vision for world class commissioning,’

⁷ DH (2009) ‘The NHS Operating Framework for England 2001/11.’

⁸ DH (2007) Commissioning Framework for Health and Well Being

The IPC commissioning framework is the most commonly used (see Figure 1) and shows the key activities involved in that cycle of commissioning. It emphasises that all of the four elements of the cycle (analyse, plan, do and review) are sequential and of equal importance, that is that commissioners and contractors should spend equal time, energy and attention on the four elements. Furthermore it stresses that the commissioning process should be equitable and transparent, and open to influence from all stakeholders via an on-going dialogue with patients/service users and providers.

Figure 1 the IPC Commissioning Framework

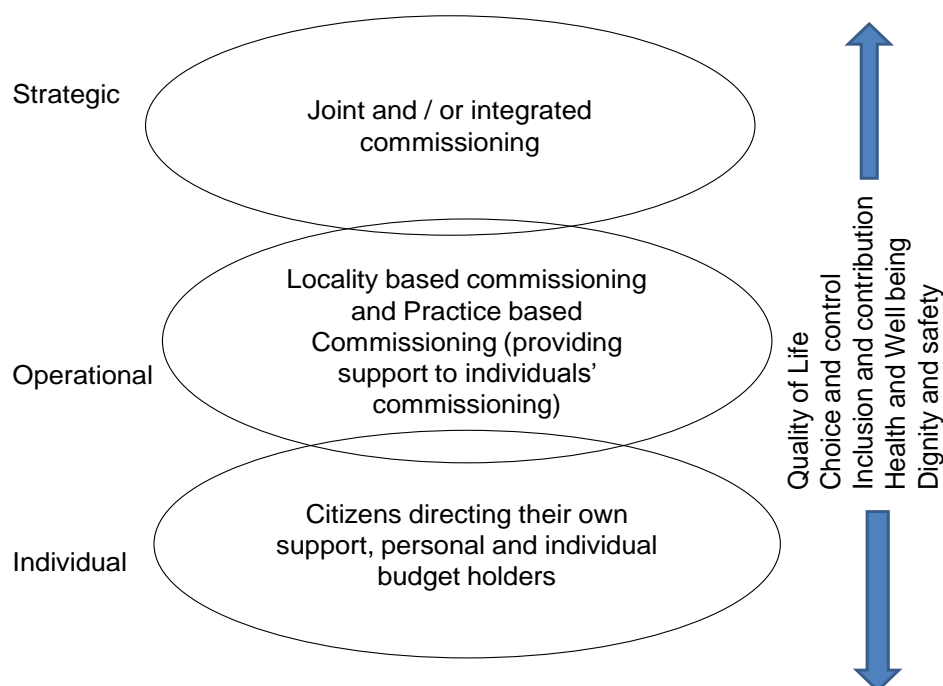


2.1 Multi-layered Commissioning

The DH has published a framework for local authority commissioners and this highlights the need to view commissioning as operating at a range of levels (layers) as is illustrated in Figure 2.

This framework is based on an approach to commissioning characterised by a number of key principles. This does not imply a one size fits all approach but it does emphasise the need for local economies to ensure that their commissioning arrangements are underpinned by a set of principles that are consistent with and make choice and control a reality for all. In particular, it enables local commissioners to focus on and identify the necessary changes in relationships between the key participants (individuals, carers, providers, and commissioners at all levels).

Figure 2 Multi-Layered Commissioning⁹



In understanding the relational impact of introducing an integrated commissioning approach, in the context of increasing personalisation and self directed support, undertaking a relational health assessment alongside the tools and assessment frameworks suggested in this paper should also be considered¹⁰. Such an assessment would enable local partners to consider their readiness for change and therefore the likelihood of sustainable solutions. Such an assessment gives consideration to:

- The 'directness' of communication that produces 'connectedness' and clarity in communication;
- The 'continuity' of relationships bringing meaning and belonging to a relationships and therefore momentum, and growth;
- The 'multiplexity' of relationship giving context and the ability to read situations and respond to changing needs;
- The 'parity' in relationships bringing mutual respect and therefore participation and investment;

⁹ DH (2008) Commissioning for Personalisation – a commissioning framework for local authority commissioners (adapted from a diagram p. 16)

¹⁰ For treatment of this issue consider the research paper 'Self Directed Support: The Challenge of New Relationships' John Ashcroft, Relationships Foundation (November 2009) available at www.thewholesystem.co.uk

- The ‘commonality’ in relationships that builds shared purpose and results in motivation and synergy.

This ‘multi –layered’ commissioning framework suggests the following set of principles:

- Empowering citizens to direct their own support.
- Enabling people to identify what is important to them and to obtain the supports they require within their available resources.
- Building on people’s existing capacities and social networks.
- Enabling meaningful participation for citizens in the commissioning process through active co-design, co-production and co-delivery, rather than post facto consultation.
- Paying equal attention to enabling self-funders to better meet their needs as to people who rely partly or wholly on state funding.
- Working with colleagues in children’s services to empower the families of children needing support and ensure better transitions from children’s to adults’ services.
- Ensuring that there is choice in the deployment options available for people to determine the arrangements that best suit them.
- Ensuring clarity and transparency in commissioning processes.
- Not assuming that greater choice of existing services is the solution.
- Working in partnership with provider organisations and the voluntary and community sector to ensure that flexible services are available.
- Maintaining a diverse view of the market and supporting equity of opportunity for the voluntary and community sector and social enterprise.
- Prioritising the stimulation and support of User-led organisations when developing the market.
- Developing a diverse range of support planning and support brokerage options that utilise the resources of the whole community.
- Working to personalise universal as well as specialist services, across all sectors to reduce barriers for citizens with support needs wishing to access them.
- Ensuring that outcomes are at the centre of all developments designed to integrate commissioning and service delivery.

The framework sets out the key activities / tasks which are involved at each level (see Figure 3 below.) For the purposes of this paper, a summary of these is only provided in the following table and a fuller description is attached in Appendix A.

Figure 3 Key tasks / activities involved at each level in a multi-layered model of commissioning

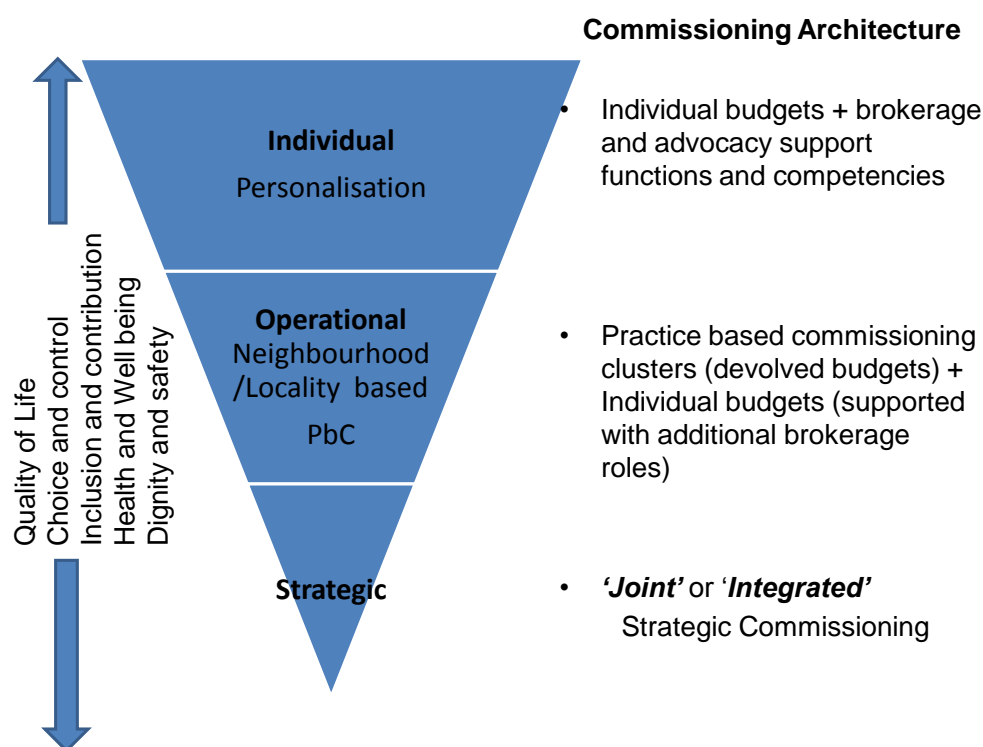
Level of commissioning	Key activities / tasks
Individual (the framework sets out the commissioning responsibilities at each of these steps)	<ol style="list-style-type: none"> 1. Set personalised budget 2. Plan Support 3. Agree Plan 4. Manage personal budget 5. Organise the support 6. Live life 7. Review and learn
Operational Commissioning	<ol style="list-style-type: none"> 1. Enabling citizens to direct their own support 2. Brokerage development 3. Engaging citizens in commissioning 4. Ensuring transparent 5. Influencing strategic commissioning
Strategic commissioning	<ol style="list-style-type: none"> 1. Identifying needs and resources 2. Agreeing key priorities – identifying opportunities for market 3. Reviewing strategic commissioning arrangements 4. Programme and project management 5. Pooling and personalising budgets Workforce development 6. Market development 7. Brokerage and advocacy development 8. Community development 9. Developing 'universal' services 10. Developing micro-markets 11. Provider development

When considering the model of commissioning, it is important to recognise that commissioning takes place at many levels in respect of different segments of the population and for different services (some of which are seen to be best commissioned nationally, regionally or locally).

This range tends to be termed 'strategic/macro' commissioning through to 'micro' commissioning. However, the different elements of the commissioning process (analyse, plan, do, and review) are relevant at each level, though the focus of the activity at each level is different: service/pathway re-design at the macro and the individual's journey at the micro level. Commissioning competencies are required at each and all levels if commissioning is to be effective.

In addition, it is important to consider the appropriate commissioning architecture and governance arrangements for each and all levels as is illustrated in Figure 4

Figure 4 Multi-Layered Commissioning and Associated Commissioning Architecture



3

Broadly there are four different models of joint commissioning currently in practice nationally¹¹:

- Lead commissioning: planning and strategy are joint initiatives, but the commissioning strategy is not a joint activity;
- Planning and strategy and commissioning strategies are joint, but one organisation takes the purchasing lead;
- Joint commissioning across health and social care, where all activities are joint, but staff involved remain in two separate teams / organisations;
- Fully integrated commissioning teams with pooled budgets.

Joint Commissioning is 'the process in which two or more organisations act together to co-ordinate the commissioning of services, taking joint responsibility for the translation of strategy into action.' (North West Joint Improvement Partnership, November 2009). Joint commissioning traditionally refers to the arrangements across health and social care to 'join up' local commissioning of services, for example, in mental health and learning disabilities. It is often accompanied by what were known as Health Act Flexibilities, or Section 31

¹¹ North West Joint Improvement Partnership project (2009) Analysis of Policy in Relation to Commissioning Skills

agreements, latterly Section 75 agreements (Section 75, NHS Act 2006) to support, for example, pooling of identified, ring-fenced resources¹².

Integrated commissioning takes the joint health and social care approach further, to encompass a wider range of partners, with the aim of addressing the complex needs of individual and communities in a 'holistic' way. This integrated approach is located in wider strategic structures, for example the Local Strategic Partnership (LSP) and it supports wider strategic initiatives, for example Local Area Agreements.

Hudson¹³ describes integrated commissioning as different to joint commissioning in terms of:

- Scale – from margin to mainstream
- Ambition – from single service to multi-service and systemic change
- Governance – from individual 'charismatic' lead to system-wide, transparent governance and accountability
- Stake holding – from few to many

Hudson further reports that integrated commissioning is being pushed by five factors:

- Efficiency / VFM – achieving efficiency through shared strategic planning and pooled budgets
- The Place Agenda – under Local Area Agreements, Total Place – local delivery focus
- Personalisation – to develop coherent services tailored to individual needs
- Prevention – to drive efficiency and improve individual's quality of life
- Care Closer to Home – integrated systems to enable more care closer to home

Prior to making a decision about the future ambition of joint or integrated working, a clear pathway and process needs to be agreed locally to assess where the current partnership arrangements are along this continuum. The following section describes some of the tools / assessments frameworks which are available to enable local partners to make a sensible (honest) assessment of where they are now.

3. Assessment tools for partnership working

Self-assessment against a recognised scale has many benefits. It can enable the people who make up the partnership to consider how far the partnership has travelled to realise an articulated position. It can identify points of blockage, misunderstandings and disagreements – the first step to dealing with a problem is to identify it. Importantly, the process of self-assessment can generate conversations across the partnership to check out future ambitions about integrated working and to develop realistic and shared plans for the way forward.

There are a number of models to be used for a local partnership to assess their own current position against agreed benchmarks for joint and integrated working.

¹² Audit Commission (2009) Means to an End Joint financing across health and social care National report summary

¹³ Hudson, B 'Integrated Commissioning – The missing link?' North West JIP and University of Durham, November 2009.

3.1 Integrated Care Network Grid

The Integrated Care Network¹⁴ (ICN) developed guidance and enabling tools for local agencies¹⁵. The ICN grid draws on the World Health Organisation ‘integration framework’. The World Health Organisation Framework identifies the key features likely to be associated with integration and distinguishes them from autonomous working or a co-ordinated approach as is illustrated in Figure 5, below. Thus, an organisation can consider how decisions are made – independently, across organisations in consultation or across organisations as a single process with clear, delegated authority.

Figure 5 The WHO Framework

	Autonomy	Co-ordination	Integration
Vision of system	Individual perception	Shared commitment to improve system	Common values, all accountable
Nature of partnership	Own rules, occasional partnership	Time limited or similar co-operation projects	Formal mission statements, legislation
Use of resources	To meet self determined objectives	To meet complementary objectives, mutual reinforcement	Used according to a common framework
Decision making	Independent	Consultative	Authority delegated, single process
information	Used independently	Circulates among partners	Orientates partners work towards agreed needs

3.2 Integrated Care Network Questions

The ICN has developed a ‘check-list’ for partnership to use to generate conversations about the development of the partnership. It is suggested that these questions can be used at both macro level, for example in Cabinet discussion at the local council and at micro-level when a small scale, specific joint project is being established.

¹⁴ <http://www.dhcarenetworks.org.uk/>

¹⁵ CSIP Integrated Care Network – Bringing the NHS and Local Government Together – A practical guide to integrated working (p.23)

Key questions for commissioning partnerships

Here are some key questions you can use when exploring the options for strategic commissioning partnerships.

- How will partnerships with users be established and maintained?
- How will the planning and commissioning processes be used to promote improved services and user outcomes?
- What role could a social enterprise or the third independent sector play?
- How will individual purchasers of personalised services influence strategy?
- What new resources, and what existing ones, will be made available for each of the services to be integrated?
- Who will be accountable for ensuring that the resources are used to improve the experience of service users?
- Will opportunities exist for new joint appointments at the most senior level?
- Will options for large-scale integration into a single organisation be considered, for example a Care Trust, an NHS Partnership Trust, or a particular type of Children's Trust. If so, when? if not, what other arrangements will be put in place, e.g. other uses of Health Act flexibilities?
- Will there be joint boards or management teams for particular services, geographical areas or functions? If so, what will be their delegated roles and responsibilities?
- What will be the overarching policy on transfer/employment of staff, ownership of buildings, financial management regimes, etc.?
- How will partnership with NHS Foundation Trusts be established and a market of care services developed?
- How will the process of change be resourced and managed?
- Have the partners identified a local currency for measuring achievement against local milestones and expectations?

3.3 Integrated Care Network - 'From the Ground Up'

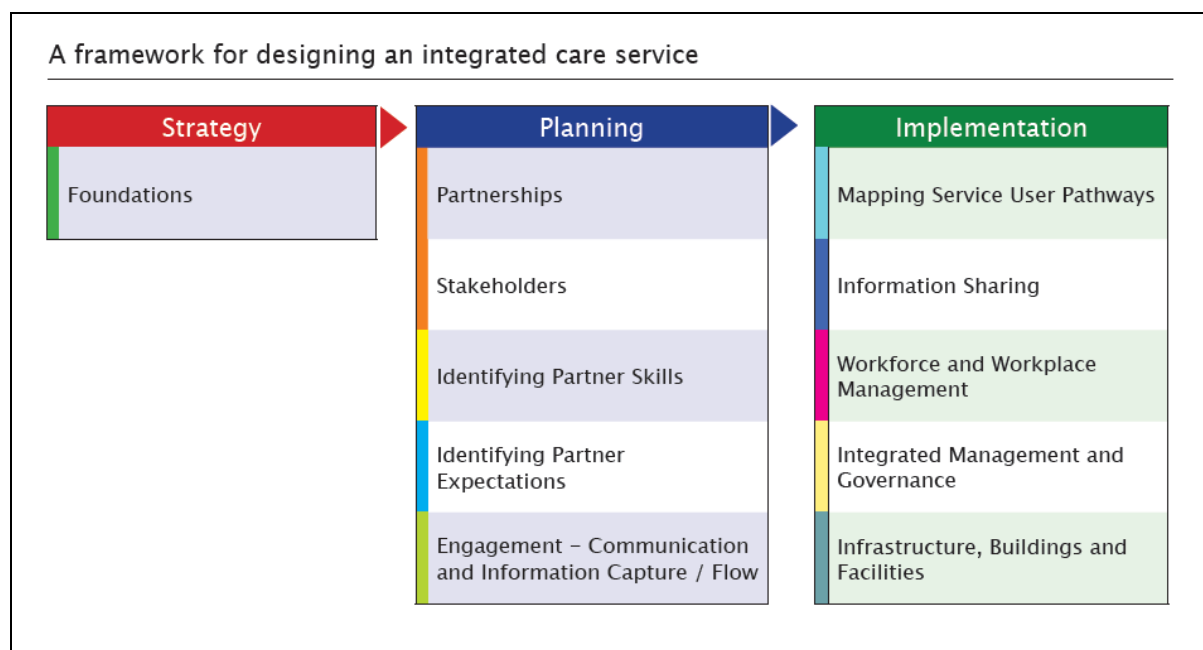
The ICN report 'From the Ground up – a report and guide to integrate design and services'¹⁶ (2010) aims to support service commissioners, including those involved in planning, service delivery, finance and infrastructure as well as local partnerships, who are looking to develop integrated care services. It outlines eight elements of integrated management practice and discusses four case studies of integration. It signposts lots of resources relevant to integrated commissioning, with particular reference to housing, adult social care and health.

From the Ground up (2010) has a companion 'easy to read' document in three parts, with a summary 'wallchart'. Part 2 of this is a toolkit¹⁷ based on three areas of work – strategy, planning and implementation. The toolkit is in workbook format with prompts at every stage. An extract from the toolkit is shown in figure 6, below.

¹⁶ DH Integrated Care Network (2010) 'From the Ground Up – a report on integrated care design and delivery.

¹⁷ http://www.dhcarenetworks.org.uk/_library/Resources/ICN/ICN_advice/Part_2_Toolkit_FP3.pdf

Figure 6 ICN Framework designing an integrated care service



Taken from ICN 'From the Ground Up' (2010) toolkit (part 2) page 1

3.4 Audit Commission – Means to an End

The Audit Commission national report, 'Means to an End'¹⁸ considers joint financing across health and social care. It recommends that local NHS bodies and councils review their current joint financing arrangements against the advice contained in the report. It sets out a checklist to measure performance of current arrangements and details the elements of a signed funding agreement.

3.5 Institute of Public Care

The Institute of Public Care (IPC) has developed a very useful document, 'A Matrix for Analysing Approaches to Commissioning across Agencies'¹⁹. This enables a more detailed joint assessment of the partnership approach, across seven commissioning areas and four levels of integration. The matrix uses the following seven commissioning and contracting areas:

- Purpose and strategy
- Stakeholder engagement
- Needs and market intelligence
- Resource allocation and management
- Market management and monitoring
- Contracting
- Commissioning function

¹⁸ http://www.audit-commission.gov.uk/nationalstudies/localgov/Pages/91029meanstoanend_copy.aspx

¹⁹ Institute of Public Care (2008) A Matrix for Analysing Approaches to Commissioning Across Agencies

The matrix also differentiates between the following 4 levels of integration:

- **Separate Approaches:** Actions and decisions are arrived at independently and without co-ordination.
- **Parallel Approaches:** Objectives, plans, actions and decisions are arrived at with reference to other agencies.
- **Joint Approaches:** Objectives, plans, actions and decisions are developed in partnership by separate agencies.
- **Integrated Approaches:** Objectives, plans, actions and decisions are arrived at through a single organisation or network.

Using the prompts within the matrix the partnership could consider, for example, stakeholder engagement and self-assess whether their approach was characteristic of a separate, parallel, joint or integrated approach. The matrix is reproduced in full in Appendix B.

4. Learning lessons from other economies

The different development of formal partnerships, such as Children's Trusts and Care Trusts demonstrate that there are different ways to adopt integrated commissioning locally.

In the development of a Care Trust Plus application, one health and social care economy assessed a number of other 'integrated' approaches, including Care Trust Plus, Deep Partnership, shared Director team and considered the drivers for change, structures, benefits, challenges and lessons learnt.²⁰ This analysis was shared with us and the summary here is based on that work.

The analysis of the different models highlighted that each model faced the difficult issues of achieving adequate financial governance and accountability, the challenge of bringing together different organisational cultures (even when pushing at an open door) and the need to navigate different structures, processes and language. Each organisation approached these issues differently, depending on shared history and drivers for change. The following provides a summary of the key findings this research.

4.1 Deep Partnership

The establishment of a 'deep partnership' was based on a long history of partnership working, where the partners felt that this basis could be developed into something deeper. There was also shared enthusiasm to make a difference in trying to provide seamless care to residents. The need for change was hastened by operational issues facing both organisations – such as increasing pressure on management costs within the NHS and the difficulty of finding a high quality, workforce of sufficient size. Alongside these drivers, external forces - such as the rapidly increasing, number of older people in the area and the lack of capacity in the markets was limiting their options – meant that they needed to find a different way of delivering health and social care services together.

4.1.1 How it works in practice

- The PCT and the Council remain as two separate statutory bodies but they have a joint management team that meets fortnightly on a mix of council and PCT issues

²⁰ Application for 'Care Trust Plus' 2009 – documents shared in confidence.

- There is one Chief Executive for the two organisations – the PCT pays for 45% of his salary
- There is still a Council cabinet and a PCT Board – there are plans to get Council representation on the PCT Board through the DASS
- Finances are kept separate but there is considerable interaction between the PCT Director of Finance and the Council Director of Resources
- The change and integration has been confined to the top levels of the organisations at the moment
- There are work streams in place to bring other parts of the organisations more closely together for all commissioning activity (except acute commissioning which will stay separate). In particular they are looking to jointly commission home care and residential care services
- Back office integration is now under consideration e.g. for procurement, so providing council access to the NHS catalogue and visa versa for PCT

4.1.2 Challenges faced

The PCT and the Council faced several challenges when establishing the deep partnership:

- | | |
|-------------------|---|
| Governance | <ul style="list-style-type: none"> • Not having a very clear vision of where they were trying to get to when they started made it quite difficult to establish a common understanding between partners • The establishment of a public service trust was not legally possible, so the deep partnership was created instead • There has apparently been a tendency for the focus to be on the organisational restructure rather than on the outcomes they are trying to achieve |
| Transition | <ul style="list-style-type: none"> • Not having a change team in place overseeing the transition meant that detailed transition planning wasn't really being done for a long time • Both organisations have different HR systems which was a challenge to manage through transition and afterwards |
| Engagement | <ul style="list-style-type: none"> • Getting senior managers on board and engaged was quite difficult and took a long time • There are big cultural differences which get in the way still, as well as practical differences e.g. pay scales • The PCT felt that they were being absorbed into the Council so were quite reluctant, and some staff still are |

4.1.3 Lessons learnt

Other organisations looking establishing a similar 'deep partnership' might want to:

- Establish a joint manager protocol for working in integrated teams

- Develop a joint values statement to help confirm the commonality between the two organisations and emphasise that they are all working towards the same goals
- Maintain two Director of Finance posts to reduce concerns about potential lack of financial control

4.2 Care Trust Plus (CTP)

This patch was experiencing rising health inequalities as well as problems in specific areas such as teenage pregnancy rates and educational attainment, alongside a rapidly ageing population. The capacity of the Council and the PCT to address these health inequalities was limited – the Council was poorly rated in its CPA and was in special measures. There was very little joint working happening previously to increase this capacity.

4.2.1 How it works in practice

The different accountabilities of the DASS have been split between:

- Delivery as part of the DASS role within the local authority (e.g. undertaking strategic needs assessment of the wider social care needs of adults);
- Delegated to the CTP for delivery but undertaken by the DASS (e.g. providing a clear leadership focus both within the LA and amongst partner agencies in providing a real and sustainable focus on adult social care); and
- Delegated to CTP for delivery (e.g. demonstrating that services are being targeted on delivering improved outcomes)

Care Management is seen as commissioning. Commissioning is done through groups of GPs brought together in clusters

4.2.2 Challenges faced

The PCT and the Council faced several challenges when establishing the Care Trust Plus:

- | | |
|----------------------|--|
| Governance | <ul style="list-style-type: none"> • Transfer of DASS role to the CTP was sought but not permitted • The DASS role is still rather unclear – the DASS ended up without enough support after disaggregation. There is some tension between the DASS role and the CTP CEO role • Who can make what decisions at what level is still an issue • It took a while for the CTP to get used to having to take into account the political element of decision-making |
| Commissioning | <ul style="list-style-type: none"> • Haven't quite worked out where to fit in PBC yet • The commissioning / provision division feels quite artificial at a micro level |
| Transition | <ul style="list-style-type: none"> • Insufficient attention has been given to safeguarding adults throughout • Bringing together the two different cultures (health and social care) was quite difficult • The TUPE from LA to health has been straightforward – 150 people have |

moved into the health scheme through open admissions agreement but people are more reluctant to move from the NHS to the LA (don't want to leave the "health family")

Finance

- The difficulty was how little each side understood each others' finance systems and budgets – project managed the process over a year across 6 task groups
- Social care budgets haven't yet been devolved to the CTP - being cautious and social care funding is being run separate until it makes sense to pool them

4.2.3 Lessons Learnt

Other organisations looking establishing a similar 'Care Trust Plus' might want to:

- Put in place a legal agreement between the Council and the NHS for the CTP. It is a 3 year strategic agreement with additional financial and performance agreements
- Develop a new Care Trust appraisal process as the Care Trust constitution process is a bit outdated
- Establish good relationships between the Non Executive Directors and the elected members to help the transition

4.3 Care Trust

Before the Care Trust was established, front line staff, service users and the voluntary sectors all felt that better outcomes and quality could be achieved by integration and that this would improve their ability to focus on customer need. Retaining a local health service was also a driver - there was a strong recognition of the value of having co-terminosity between NHS and Local Authority and which was felt to be under threat. There was public concern that the bigger neighbouring PCTs would 'take over' especially in context of a number of NHS mergers. Reducing the perceived 'democratic deficit' in the NHS was also a concern for some stakeholders. Finally, there was also a strong commitment in the Council and in the PCT to achieving the greatest possible efficiencies by integrating functions.

4.3.1 How it works in practice

- The Chief Executive was appointed through the NHS PCT recruitment process but is also the DASS. A Section 113 agreement is in place whereby the NHS in effect seconds the post holder to the council to fulfil this function
- The Care Trust fulfils all the functions of an NHS Primary Care Trust with the addition of responsibility for commissioning and delivery of Adult Social Care and Supporting People.
- The Care Trust delivers commissioning functions through an increasingly integrated structure. Commissioners' commission across pathways, Public Health staff support needs analysis, critical appraisal, reviews and evidence building, user and public engagement is within a single function and support services are delivered across functions.

- Clinical and professional governance, Finance, IT, and HR functions work across health and social care
- The Council transfers the funding for Social Care and Supporting People to the NHS Care Trust. Financial reporting for Social Care is via the Cabinet Member as well as the CT Board
- 3 councillors sit as NEDs on the Care Trust Board

4.4 Summary of lessons learnt

In reviewing the experiences of these other economies, the aspirational Care Trust Plus identified several challenges in their transformational journey towards achieving greater integration despite their history of effective partnership working. These challenges can be summarised as follows:

- Having a very clear vision and destination which is shared across all partner organisations and agreeing a clear set of milestones along the pathway;
- Ensuring that all senior leaders across the partner organisations are fully and actively engaged throughout the whole transformational process;
- Ensuring that the focus remains on improving outcomes and not on changing organisational structures;
- Establishing a transparent decision making process, which is respected by all partner organisations;
- Working together to address the cultural differences as they were brought together;
- Creating the time and developing the capacity to deliver the transition process;
- Achieving a mutual understanding of each other's financial systems and budgets;

5. Conclusion

This discussion paper has been produced to support local health and social care economies in their development of a strategic model of integrated commissioning. It signals that the national agenda is pushing for more formal and fuller integration across local authority and NHS commissioners and against this context.

It highlights the importance of achieving clarity on the terminology associated with 'joint' and 'integrated' commissioning models and draws out the competencies and architecture required at all levels to support a 'multi-layered' model of integrated commissioning which is required if local commissioning (*at all levels*) is to be contemporary and 'fit for purpose' in the context of delivering personalisation and self directed support.

It provides a number of assessment tools and frameworks that can be used to undertake a 'self assessment' and generate honest conversations across the extent to which partnership working currently operates and to assess the feasibility of future ambitions of integrated working. From the learning across other economies, there is recognition of the significant challenges facing organisations in achieving integrated commissioning even when there has been a history of effective partnership working.

Where there is local intent to develop a more integrated approach to commissioning, in the context of challenging local circumstances, the local strategic leaders will need to draw on each others' strengths, work in a collaborative way, ensure that there is clarity on the 'destination' for integrated commissioning and develop the leadership, capacity and capability within commissioning.

If the locally agreed direction of travel / destination is integrated commissioning, a local action plan must be jointly developed to achieve this goal, including, for example:

1. Undertake a re-appraisal of the current 'position' on partnership working from the perspective of each partner organisation in the light of the NHS World Class Commissioning Programme and the Local Authorities 'Transformation' Programme using one of the suggested assessment tools for commissioning alongside a relational health audit methodology;
2. Undertake a robust transparent 'option appraisal' (including benefits and risks) which will enable each partner organisation to re-state, with sufficient detail and ownership, the nature and level of integrated, coalition based commissioning they are agreeing to at a local level;
3. In the event of a decision to move forward with fuller integration a commitment is required to a 'system wide' organisational development approach to developing the leadership, competencies, capacity and capability within the joint commissioning unit beyond that which is currently available;
4. A commitment to establishing a 'genuine' system –wide sustainable engagement process that is multi- professional and across all levels of the partner organisations.

Appendix A – Activities / tasks associated with different levels of a Multi-layered Commissioning Model

Level of commissioning	Key activities / tasks
Individual (the framework sets out the commissioning responsibilities at each of these steps)	<ol style="list-style-type: none"> 1. Set personalised budget - Transparent allocation of resources up-front 2. Plan Support The individual, with help where required, works out how best to use the money to meet their needs in a way that suits them 3. Agree Plan The individual verified their assessment and support plan with the council or other funding provider 4. Manage personal budget The individual decides how to manage their budget with any support required (broker, family, provider, trust etc) 5. Organise the support The individual organises for the things in their support plan to be purchased or to happen 6. Live life The individual uses their support flexibly and with as few restrictions as possible to live a full life 7. Review and learn The individual checks with the care manager how things are going and makes changes as necessary
Operational Commissioning	<ol style="list-style-type: none"> 1. Enabling citizens to direct their own support: There are a number of key considerations for ensuring that people are enabled to direct their own support, ranging from the provision of information and training opportunities to more direct interventions, including advocacy, advice, signposting facilitating consortia purchasing arrangements, 2. Brokerage development – is an important task for commissioners at operational and strategic level. Emerging practice of sustainable models of brokerage support can be shared with providers, user groups and the wider voluntary and community sector and targeted capacity building funding may also be considered. 3. Engaging citizens in commissioning – by developing outlets and formal mechanisms for citizens to be actively involved in service design and priority setting – not just as feedback. This may cover both universal and specialist services that lie outside of personal budgets as well as those services that can be directly purchased by individuals. 4. Ensuring transparent pricing – by working closely with in-house providers and commissioned service providers to set prices at a level that retains their economic viability. 5. Influencing strategic commissioning – whilst much could be achieved through locality based commissioning some service changes required at local level are best achieved through strategic commissioning. There need to be straightforward ways in which local joint commissioning networks can easily communicate these changes to strategic joint commissioners.

<p>Strategic commissioning</p>	<ol style="list-style-type: none"> 1. Identifying needs and resources – individual support plans provide an important way in which needs and the resources being used to meet them can be identified. A process needs to be in place to aggregate these plans and, in dialogue with the integrated service delivery networks, understand the strategic implications. 2. Agreeing key priorities – identifying opportunities for market development, securing appropriate services and being able to make best use of universal services will lead to the identification of a long list of potential priorities. These will encompass: community development requirements; gaps in the market; the need for person centred forms of service integration; the greater personalisation of existing universal and specialist services; and the new strategic arrangements needed to support these changes. 3. Reviewing strategic commissioning arrangements – an effective approach to personalisation requires changes well outside of health and social care. These changes relate to the overall ‘place shaping’ agenda and need to be incorporated into the community strategy and be part of the core work programme of the local strategic partnership (LSP). 4. Programme and project management – establishing clear project and programme management arrangements that enable the portfolio of changes to be coherently implemented with a clear focus on interdependencies, outcomes and realising benefits. A fully populated project portfolio might include projects relating to the uptake of personal budgets, the organisation and structure of departments, business processes, community development, market development, workforce, and the back office functions and IT requirements to support these changes. 5. Pooling and personalising budgets – some priorities may require further extensions of pooled funding or personalised budgets within other service sectors, as with, individual learning budgets and choice base lettings in housing. The former may require the use of Section 75 flexibilities, Sec 10 Local Government Act agreements or the flexibilities that could be obtained through a local or multi area agreement. 6. Workforce development – Staff should be enabled to actively adopt the principles of self-directed support in their working practices. 7. Market development: is a process involving a partnership between citizens, providers and local authority commissioners. It seeks to shape the type, availability, flexibility and responsiveness of local services to ensure equality of access for all those managing their support to the kinds of things they want to buy. 8. Brokerage and advocacy development – Putting People First describes a key objective of social care reform as being the development of ‘a universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding. 9. Community development – Commissioners can play an important role in supporting certain community based services that are unlikely to be sustained by individual purchasers but contribute to shaping a supportive environment for that market. 10. Developing ‘universal’ services – Commissioners can play an important role in focusing ‘universal’ services on the diversity of citizens’ needs and the removal of barriers to universal access. 11. Developing micro-markets – new and existing forms of small-scale provision can also be encouraged to expand choice in response to individual, niche and culturally specific wants and needs. 12. Provider development – including open dialogue about the direction of travel, staged approach to moving from block contracts to individualised support / budgets and other opportunities to advertise (market navigation).
---------------------------------------	--

Appendix B – Matrix for Analysing Approaches to Commissioning Across Agencies

IPC have drawn on a range of materials, particularly Integrated Working: A Guide (Integrated Care Network 2004), A Catalyst for Change (Department of Health, 2004) and Making Ends Meet (Audit Commission 2003), plus its own experience of working on the commissioning of public care services throughout the country to develop a matrix for analysing the extent to which different areas of the commissioning and contracting process are integrated across agencies. The matrix uses the following 7 commissioning and contracting areas:

- Purpose and strategy
- Stakeholder engagement
- Needs and market intelligence
- Resource allocation and management
- Market management and monitoring
- Contracting
- Commissioning function

The matrix also differentiates between the following 4 levels of integration:

- Separate Approaches: Actions and decisions are arrived at independently and without co-ordination.
- Parallel Approaches: Objectives, plans, actions and decisions are arrived at with reference to other agencies.
- Joint Approaches: Objectives, plans, actions and decisions are developed in partnership by separate agencies.
- Integrated Approaches: Objectives, plans, actions and decisions are arrived at through a single organisation or network.

Examples of activities at each level are described in the table below.

Areas	Separate Approaches Objectives, plans, decisions, and actions are arrived at independently and without co-ordination.	Parallel Approaches Objectives, plans, decisions, and actions are arrived at with reference to other agencies.	Joint Approaches Objectives, plans, decisions, and actions are arrived at in partnership by separate agencies.	Integrated Approaches Objectives, plans, decisions, and actions are arrived at through a single organisation or network.
Purpose and Strategy	<ul style="list-style-type: none"> Agencies develop services to meet their own priorities. Single agency planning documents do not include key partner's priorities and drivers. Single-agency commissioning strategies. 	<ul style="list-style-type: none"> Systematic analysis of partner agency perspectives, issues and concerns. Liaison in the production of separate strategies. Strategies reference and address partners' issues. 	<ul style="list-style-type: none"> Shared commitment to improve outcomes across client group. Joint strategy development teams producing common strategies. 	<ul style="list-style-type: none"> Inclusive planning and decision process as an integral partner A transparent relationship between integrated bodies Single agency with one commissioning function.
Stakeholder Engagement	<ul style="list-style-type: none"> Public meetings, conferences, feedback are designed and delivered independently. 	<ul style="list-style-type: none"> Information from service users or service providers is shared when clearly relevant. 	<ul style="list-style-type: none"> Agencies jointly design and manage consultation and feedback activities. 	<ul style="list-style-type: none"> A single team is responsible for systematic planning and delivery of provider consultation to inform a single strategy.
Needs and Market Intelligence	<ul style="list-style-type: none"> Needs analysis is undertaken independently, and deals with very specific aspects of population need. Agencies use provider intelligence for the purpose of identifying their own commissioning priorities only. 	<ul style="list-style-type: none"> Separate needs analyses shared by agencies. Separate cost, benchmarking and general market intelligence shared by agencies. 	<ul style="list-style-type: none"> Jointly designed population needs analysis. Joint working groups to review market mix. 	<ul style="list-style-type: none"> Single projects undertaking needs and market analysis and using these to inform commissioning and contracting priorities. Single research, analysis, public health teams.
Resource allocation and management	<ul style="list-style-type: none"> Budgets are used solely to meet self-determined objectives. The financial impact of services and policies on other agencies is not considered. 	<ul style="list-style-type: none"> Agencies allocate some resources to address issues of common concern. 	<ul style="list-style-type: none"> Agencies identify pooled budgets for particular areas, and a joint approach to decision making on budget allocation to meet common objectives. Use of Health Act Flexibilities. 	<ul style="list-style-type: none"> Pooled budgets within a single agency or network, to meet combined needs identified for the population.

Areas	Separate Approaches Objectives, plans, decisions, and actions are arrived at independently and without co-ordination.	Parallel Approaches Objectives, plans, decisions, and actions are arrived at with reference to other agencies.	Joint Approaches Objectives, plans, decisions, and actions are arrived at in partnership by separate agencies.	Integrated Approaches Objectives, plans, decisions, and actions are arrived at through a single organisation or network.
Market management and monitoring	<ul style="list-style-type: none"> Market management sited in separate organisations. A fragmented approach to use of providers and resources. Provider performance information not shared between agencies. 	<ul style="list-style-type: none"> Performance measurement information shared to promote commonality and consistency. Agencies inform each other of performance improvement needs. 	<ul style="list-style-type: none"> Multi-agency review groups ensure robust joint arrangements for the collection and interpretation of performance information. Sharing of risk with market development. 	<ul style="list-style-type: none"> Integrated monitoring and review arrangements that result in a shared understanding of the effectiveness of current services and the evidence for changes in the future.
Contracting	<ul style="list-style-type: none"> Contract compliance information is used independent of other sources and solely within the organisation. 	<ul style="list-style-type: none"> Agencies inform each other of purchasing intentions. Agencies share information about contracts and intelligence about performance where relevant. 	<ul style="list-style-type: none"> Agencies issue joint block contracts or share contract risk. Standard joint contract terms are realistic and deliverable by providers. 	<ul style="list-style-type: none"> Single function responsible for managing contracts to meet a single commissioning agenda.
Commissioning Functions	<ul style="list-style-type: none"> Agencies have their own teams to support their commissioning activities. 	<ul style="list-style-type: none"> Agencies liaise re commissioning activities (e.g. needs analysis, monitoring of individual agency strategies) in order to support common commissioning objectives. Identified common training and development needs within agencies. 	<ul style="list-style-type: none"> Emerging hybrid roles support a joint strategic commissioning function across agencies. A clear understanding of the resources and skills required to provide support to joint strategic commissioning Joint appointments of commissioning staff. 	<ul style="list-style-type: none"> Integrated commissioning function, e.g. a single manager with responsibility for managing commissioning and contracting within a single organisation or network.