

**Integrating Practice Based and Social Care
Commissioning**

Eastern Regional Pilot Network

Final Report

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This report is jointly published by Eastern Development Centre, (formerly CSIP Eastern Region), and the Integrated Care Network. Please note that from 31 March 2009 CSIP as a separate entity will cease and new arrangements will be in place to incorporate some of its current duties. The ICN will continue in its role and may be contacted at mbicn@dh.gsi.gov.uk and www.networks.csip.org.uk/icn

Background, Aims and Objectives

- 1) Major programmes of systems reform are being implemented in the NHS and social care. In addition, new frameworks of central/local relationships are being developed in both the NHS and local government. Both sets of changes have implications for relationships between and within, services. Underlying all these initiatives is the shift towards more effective and person centred commissioning based on local needs as well as national targets. At least initially, however, the policies for systems reform in health and social care, respectively, were, in some respects' conceived and developed separately
- 2) Although they share some common philosophical or conceptual roots, they are being expressed and pursued in somewhat different forms:
 - a) Social care is pursuing a strategy of 'total transformation' based on choice and control, early intervention, prevention and enablement. All councils are expected to allocate a personal budget to everyone eligible for statutory support, with many more people having the opportunity to take all or part of this budget as a direct payment (Department of Health 2008).
 - b) In the NHS, systems reform emphasises improved access, choice (especially through choose and book), promoting health, prevention and reducing health inequalities. Payment by results and practice based commissioning are the main tools to support individualised care pathways.
- 3) These directions of travel were confirmed in the 2006 White Paper 'Our Health, Our Care, Our Say' (DH 2006), which also emphasised the necessity for adopting a whole systems approach across the NHS and local government. A further White Paper 'Strong and Prosperous Communities' (CLG 2006) together with subsequent legislation¹, provided the basis for joint working based on a new local performance management framework, Local Area Agreements and statutory duties of cooperation. In addition, the interim report of the NHS Next Stage Review (Darzi 2007) encouraged practice based commissioners to adopt existing powers to use NHS funds more flexibly to secure alternatives to traditional NHS provision. This endorsement was reinforced by the Operating Framework 2008/09 and subsequent guidance (DH 2007a and 2007b).
- 4) During 2006 the Integrated Care Network launched a national conference and programme of discussion that was to inform debate upon the notion of Practice Based Commissioning in Partnership and later the drafting for DH of the guide, 'Practice Based Commissioning An Introduction For a Local

¹ The Local Government and Public Involvement in Health Act 2007

Authority Audience' including some good practice case examples. The conference findings were also used to inform the drafting of the DH Guide to Commissioning for Health and Well Being

- 5) The national conference was followed by a series of regional conferences to inform good practice

In the Autumn of 2006, CSIP Eastern Region, had also secured interest in principle from Eastern local authorities and PCTs for the establishment of a regional network of pilot sites to explore 'the potential benefits for service users of locality based, needs led approaches to joint commissioning'. The initiative was part of CSIP Eastern's programmes for commissioning development and implementation support for "Our Health, Our Care, Our Say" and was supported by the Integrated Care Network's programme of supporting capacity building and the capability for integrated working at a regional level- as a part of the ICN regional conference programme

The proposed network of pilots had been conceived in advance of the detailed PBC implementation guidance for NHS which emerged during 2007 and 2008

These approaches by CSIP Eastern Region and ICN were both based on recognition of the need to understand and manage the interdependencies between the systems reform in the NHS, social care and local governance more generally. In particular, it recognised that the critical area of interdependency would be the interface between social and primary care, the point at which resources were committed to individuals with long term conditions and continuing care needs.

- 6) Accordingly, In November 2006, CSIP Eastern invited formal expressions of interest to join the proposed regional network as a vehicle to support learning and share best practice. The invitation noted that practice based commissioning (PbC) was a 'pivotal' element of system reforms. Considerable interest was emerging in the potential of practice based commissioning for community care services (even though national tariffs and currencies are yet to be developed and agreed). However, there were 'few examples of initiatives between commissioning practices/consortia and County/Unitary Councils to explore the potential for improved outcomes for local populations resulting from an integrated approach to local commissioning' (Integrated Care Network 2008).
- 7) The invitation also emphasised that the pilots and learning network would be taken forward in the context of '*the NHS system reforms, recent Commissioning framework guidance, the Health and Social Care White Paper and proposals for Local Government reform*'. Largely because of the timing and demands of this wider change agenda, a number of localities were unable to proceed with the pilots they had originally

envisaged. However, three pilot sites were accepted for inclusion in the network, with effect from April 2007. The three sites were:

- a) Stevenage in Hertfordshire with a focus on mental health;
 - b) North East Essex with a focus on intermediate care; and
 - c) Suffolk County with a focus on a partnership approach to PBC and social care in Suffolk, including the provision of personal budgets and individual health SLAs
- 8) As evaluation is an essential element of a learning network, CSIP Eastern secured academic support from Gerald Wistow, Visiting Professor of Social Policy at the LSE and Amanda Howe, Professor of General Practice at the University of East Anglia. They were commissioned separately to conduct a two tier evaluation. Professor Howe was to focus on the pilots' outputs and outcomes at the level of individuals and their informal carers. By contrast, Professor Wistow was to conduct a process evaluation with particular reference to the organisational implications of integrating PBC and social care commissioning. The remainder of this paper is devoted to that evaluation.
- 9) The primary purpose of this study was to capture and synthesise learning from the pilots about the ways in which they were able to integrate elements of PBC and social care commissioning for improved outcomes in specific localities. In the latter respect, it should be noted that the CSIP invitation specified that individual pilots 'would be expected to be consistent with identified LAA/LSP priorities and any specific local care group strategies'. The clear implication, therefore, was that the pilots should be integral elements of mainstream commissioning programmes rather than discrete 'add ons'.
- 10) The call for expressions of interest identified an extensive range of what were described as 'objectives' and 'additional outcomes'. The proposal prepared for the process evaluation suggested that they could be grouped into three broad categories:
- a) The **outcomes** of commissioning for individuals and the communities where they lived, based on their needs and preferences
 - b) The **focus** of commissioning on re-designed care pathways and, where necessary, re-configured supply systems to achieve such outcomes.
 - c) The organisational **arrangements and infrastructures** needed to commission those outcomes through specified care pathways and supply structures
- 11) The ordering of these three principal categories was not random, though nor did it presume a linear relationship between them. Rather, it was selected to reflect the priority within government modernisation and transformation programmes to placing the public at the centre of public

service reform. In addition, evidence from several decades of attempts to strengthen NHS and local government integration that the emphasis had been on designing the structures and processes for joint working rather than securing jointly agreed ends for local residents. In effect, means had become ends in themselves. If the clarification of needs and outcomes was the starting point for the pilots, a more appropriate relationship between means and ends might be developed.

12) The evaluation proposal allocated each of the objectives and outcomes specified in the call for expressions of interest to one of these three principal categories. A small number appeared to relate to more than one category and they were placed in what seemed to be the one most relevant to their purpose. The resulting tabulation of aims and objectives provided the initial evaluation framework (see Figure 1). By the time the proposal was discussed with the network (May 2006), a further set of potential evaluation criteria had emerged in the form of the 'eight steps' to more effective joint commissioning in the draft 'Commissioning Framework for Health and Wellbeing' (DH 2007c).

13) These steps comprised:

- a) *putting people at the centre of commissioning*
- b) *understanding the needs of populations and individuals*
- c) *sharing and using information more effectively*
- d) *assuring high-quality providers for all services*
- e) *recognising the interdependence between work, health and well-being*
- f) *developing incentives for commissioning for health and well-being*
- g) *making it happen – accountability*
- h) *making it happen – capability and leadership*

14) Although the March 2007 publication of this consultation document superseded the call for expressions of interest, it was expected to be relevant to the pilots. In practice, it offered a source of practical support since each of the eight steps was accompanied an inventory of tools and resources to assist their development. From the perspective of the process evaluation, the document provided at least a checklist of characteristics believed by the centre to promote more effective joint commissioning. The timing of the evaluation meant it was not feasible to 'test' the value of the commissioning guidance. Such an exercise would also require much more than the 20 days available to conduct the evaluation and support the learning network. However, it was agreed that the pilots' experiences were likely to be highly relevant to at least some aspects of the commissioning framework and that their progress should be reviewed from that perspective.

15) In addition, the evaluation recognised that 'integration' had many faces. It was used both generically to embrace a wide range of organisational

arrangements and also very specifically to cover the unification of structures and/or processes. This report does not adopt a normative stance in relation to specific forms of integration. Rather, it recognises a continuum covering a wide range of approaches including: alignment, co-location, joint appointments, team working, lead or transferred responsibilities and organisational unification. It also recognises that integration is necessary at a minimum of two levels: the strategic whole systems level; and also at the individual whole person level. Integration, of whatever form, is sought at both levels in order to secure more holistic assessments of need and responses to need. At the end of the day, the underlying purpose of integrated working is to enable individuals to be regarded as whole people in the context of their families, other supporters and communities.

16) Against this background, the approach adopted by the evaluation was to visit each of the three sites in May 2007 and January 2008. On most occasions, the evaluator was accompanied by the CSIP (Eastern) Commissioning Lead as a non-participant observer. Group interviews were conducted each time, using pre-prepared interview schedules designed to permit an exploration of issues identified from the framework of pilot aims and objectives and the eight steps to commissioning (see Appendix 1 and 2). Notes were taken and written up after the interviews. In addition, the evaluator attended each of the network meetings, at which projects provided progress updates and was able to follow up issues raised in the meetings or more privately. Again these discussions were noted and, together with the interview data, have been analysed and drawn on in the preparation of this report. Each of the pilot sites also made a presentation to major regional conference in November 2007, which was designed by CSIP, the ICN and the evaluator to provide an opportunity for all stakeholders to take stock at the six month point in the pilot programme. Finally, a number of documents were made available to the evaluator before and after interviews as well as at network meetings.

Pilot Sites

17) The three pilot sites (Hertfordshire, North East Essex and Suffolk) covered different types of geographical area and user group. Each had been subject to organisational change as a result of the implementation of the policy initiated in 'Commissioning a Patient-led NHS' (DH 2005). Financial deficits in the health service had similarly cast a shadow over NHS and local government relationships and councils were identifying gaps between anticipated needs and resources which challenged the sustainability of existing services. On the local authority side, children's and adult services had been disaggregated in the three councils and in one area a District Council was bidding for unitary status. Despite all these challenges, each of the sites had identified the CSIP call for expressions of interest as an opportunity to improve outcomes for local people through locality focussed

commissioning across the boundaries of the health service and local government. Each of the pilots is described in the following paragraphs, together with the state of play in January 2008 in respect of progress in meeting their goals

Hertfordshire

- 18) The Hertfordshire pilot was focussed on the Stevenage PbC consortium which had been selected through the county wide joint commissioning arrangements to participate in the network following an internal bidding process. The principal actors were a GP newly funded by the project to fulfil a lead role in mental health and an existing mental health joint commissioner. The pre-existing level of inter-agency integration was relatively high and formalised. There were established joint commissioning structures and posts for mental health (and other) services, together with a mental health trust providing both health and social care services. Notwithstanding the substantial reduction in PCT numbers within the county from October 2006, the joint commissioning arrangements for Stevenage appeared to have been subject to relatively little discontinuity of structures, personnel or relationships compared with the other two sites.
- 19) The overall objective of the Stevenage pilot was to test and develop a model of practice based joint commissioning (PBjC) across health and social care that allowed GPs to deploy social care as well as health resources. This combining of resources was expected to be facilitated by the established joint commissioning arrangements and the pre-existing pooled budget for mental health, albeit one which was primarily allocated to acute care pathways.
- 20) A project initiation document (PID) was prepared in April 2007 specifying the following objectives:
- a) *To implement a model practice based joint commissioning (project) for Adults of Working Age Mental Health for the population of Stevenage.*
 - b) *To identify priorities and commission a model of Adult Mental Health care tailored to meet the requirements of this population.*
 - c) *To engage all relevant stakeholders in the planning and implementation of this development including local service users and carers.*
 - d) *To work within an agreed indicative JCPB budget.*
- 21) The project's target population was those people served by Stevenage GPs and suffering from mild or moderate mental illness. It was perceived to include a *'big group who are not getting adequate care – not sick enough for acute care and not properly managed in primary care.'* In addition, the project was aimed at people who *'ended up in secondary care.....but could so easily be managed in primary care'*. New care pathways were to be designed for these, therefore. They would be based

on a model for a primary care mental health strategy which had been implemented and evaluated nationally and elsewhere in the county but which would be tailored to the particular mix of needs and resources in Stevenage. At the core of the new pathways was the NICE. Stepped Care for the Treatment of Anxiety and Depression Model. Consequently, the locality was seeking to commission from the existing secondary provider, a model of Enhanced Primary Mental Health Care (EPMHC) which supports the principles of a stepped care approach to service delivery. The model was seen as the route to meeting needs which were either currently unmet or inappropriately met. In both cases, the project was expected to lead to fewer referrals to acute services through the provision of a wider range of services in primary care.

- 22) GPs from the Stevenage PbC consortium were to be centrally engaged in the pilot. Two sessions a week were funded for lead GPs to conduct *'a needs assessment, visiting all GPs....telling them about the project and asking them what problems they are experiencing with the current system and what they think would improve it'*. The two lead GPs also met the consultants to get their input into specifying primary care based mental health pathways. For the GPs, the project was seen as a means extending their menu of options and enabling their patients to get better access to mental health services, especially psychological services. It would also potentially reduce spending on drugs and possibly demand on GP time since they would be able to draw on the resources of psychological therapy and counselling staff working in primary care settings where possible.
- 23) Commissioners, including lead GPs, were confident about the design of new care pathways which would produce better outcomes for patients. *'We know what we want. If we have the front end development in primary care, we can reduce by 40% the activity going into secondary care'* (as demonstrated by evidence from the evaluation of a previous pilot in the county as well as nationally). Similarly there was confidence that evidence from elsewhere showed that primary care mental health services based on brief interventions could reduce sickness absences.
- 24) Users and carers were seen as key stakeholders in the project, though their engagement was slower to develop than that of GPs and the mental health trust. The latter was explicitly seen as a partner in the project from the outset, not least because it was perceived to *'feel challenged'* by the project in a context where mental health resources had been subject to three annual rounds of 5% spending reductions. In addition, the trust was looking for some measure of financial certainty as it prepared its bid for foundation status. The strategy employed by the commissioners was to avoid immediate threats to the provider's funding base by guaranteeing that the trust would be contracted to provide the new primary care based services for three years. After that, the commissioners reserved the right to

tender for those new services.

- 25) This approach had two consequences. First, it reduced the incentive for the trust to oppose the new care pathways on the grounds of loss of income. What might otherwise have been seen as an external threat to de-commission its services was effectively re-defined as an internal exercise in the change of use of finance and staff. Second, it increased the incentive for the trust to redeploy its resources and provide new services which would be valued by users and GPs. Thus the effect was to give the trust a stake in both the immediate transformation of services and also their longer term quality and cost effectiveness.
- 26) By January 2008, the pilot had made considerable progress in identifying needs and implementing the new care pathway. In addition, a successful IAPT bid had been made. The initial approach to needs identification had focussed on two GPs interviewing their colleagues. These consultations with GP colleagues were subsequently reinforced by analysis of both primary and secondary care data and a literature review (the adoption of a model endorsed by NICE was also a powerful element in the overall evidence base about needs and pathways). The IAPT bid recorded that GP engagement was considered *'one of the undoubted strengths of this process.....with the Stevenage Locality Cluster Group mandating the GP lead for this pilot to take decisions on their behalf. This has also allowed for regular feedback to the cluster group throughout the process.'*
- 27) The pilot experienced some difficulty in obtaining a user perspective on need largely, it felt, because of the problem of contacting people *'who are not known to mental health services currently, for whom we believe there exists the greatest level of unmet need'*. Consequently, it commissioned Viewpoint (a user-led organisation) and Carers in Hertfordshire to undertake a series of focus groups within the locality to better inform its needs assessment. In addition, it obtained approval from the locality cluster group to use primary care diagnosis and prescribing data to target questionnaires people the pilot believed would benefit from a reconfigured care pathway. Much of the needs data was seen to have *'validated'* the care pathway, service specification and GPs' experience in their clinical practice of service gaps. A surprise reported from the carer's work was the large number (82%) who said their greatest need was *'a person to talk to' who would 'listen to them, believe them and provide confidence that action would follow'*
- 28) The re-designed care pathway was beginning to be implemented in January 2008. The enhanced primary care team was providing a single point of entry from primary care to mental health services based on two key principles: first, that treatment is the least intensive available but which still produce a significant health benefit; and, second, that treatment is monitored and 'stepped up' if there is no improvement in health. This

initiative was seen as *'the biggest single change.....which took away the problem experienced by GPs of not knowing where to refer a patient.....they are assessed now at a single point for whether they should be referred to secondary care or managed in primary care. This reconfiguration of services was, therefore, judged to 'have filled the gap and brought down the threshold for accessing services'*.

29) Engagement with users and carers had demonstrated that the location of service delivery was also important. Their preference was not only for services to be provided in Stevenage but also within primary care. This objective was contained in the specification for the services which expected EPMHC services to be delivered wherever possible within primary care. While this was not immediately possible due to space constraints, the requirement was to be reflected in the locality's LIFT developments and a number of practices were committed to the provision of premises to enable their clients to be seen in primary care facilities by the EPMHC service.

30) From a joint commissioning perspective, the pilot's underlying objective was to develop an approach that would enable PBC to commission both adult mental health and social care for their localities based on the established pooled budget and joint governance arrangements. It was accepted, however, that social care had initially been *'an afterthought for the first six months'* and that it needed *'a high level of social care (management) to advance it.'* Social care needs had, been omitted from the initial needs analysis and the pilot's focus originally had *'a medical bias....we recognise that in order for this project to be successful we must establish ways of engaging practice based commissioning consortia in addressing the social care needs of the individual- possibly through the use of individual budgets and direct payments'*. While the pilot had yet to resolve how the PBC consortium could best meet this objective, it was *'confident that measures can be implemented to promote the principles of practiced based health and social care commissioning in a way that utilises the full spectrum of resources to promote a person's independence and wellbeing and not just those aligned to health care'*.

31) For its part, social care was not in a position to contribute to this joint agenda during 2007/08. While not a national pilot for IBs, it was testing out a Resource Allocation System (RAS) for people with learning disabilities and physical disabilities. Roll out to mental health was dependent on the results of that work. In other words, social care had to complete its own development plans, systems design and learning before being able to move into a joint commissioning arena. Direct payments were *'less of a problem'* in this respect but the target population of mild and moderately ill were *'often those people who were not eligible for social care because of FACS'*. A benefit from the project was, however, that GPs developed a greater awareness of FACS and its implications for access to social care

services. Similarly the pilot raised GP awareness and understanding of personalisation initiatives in social care together with their underlying philosophy and principles: *'our work has also identified a significant interest and potential value in the use of Individual Budgets and Direct Payments to enable people to take more control of how their social care packages are delivered'*. As a result, the service specification required the mental health trust to *'enhance the choices and options available to persons with higher level mental health needs in ways that reduce their dependence on more traditional and less individualised methods of service delivery'*

32) Prior to the selection of Stevenage to be the Hertfordshire member of the network, enhanced primary care mental health services had already been developed in three localities in the county. During the course of the pilot, other PBC groups in Hertfordshire have also taken a keen interest in mental health and, through dialogue with the mental trust are reported to have redesigned their own primary care mental health services. Resources have also come to the county to develop IAPT services further complementing these developments. Because the Trust has positively engaged (as part of its Business Strategy) with PBC groups to redesign primary care, it has been difficult to some extent to identify the specific PBC contribution to this change. It is possible, of course, that such engagement was at least partly to anticipate PBC approaches and demonstrate a greater responsiveness to concerns and pressures in primary care. Nonetheless, in the absence of a more detailed and comparative study, it is difficult to reach a conclusive judgement about the impact of PBC, per se, on the re-shaping of care pathways. In addition, the area of integrated commissioning is recognised by the pilot to be one of relatively less development.

33) For all these reasons, therefore, it is possible that the pilot has served as a framework for securing in Stevenage the kind of pathway re-design which has taken place elsewhere as a result of other influences and mechanisms. Whether it has or will produce better outcomes for patients and families is beyond the scope of this study. Its ability to integrate PBC with IBs during 2008/09 will provide a test of the foundations laid down the previous year. However, it is noteworthy that the design of new care pathways has been accompanied by a significantly enhanced level of primary care involvement in identifying need from a person centred perspective together with different, evidence based ways of responding to such need.

North East Essex

34) The overall objective of the North East Essex pilot was *'to design and implement a new Intermediate Care Pathway'*. It was jointly led by the Chief Executive of the PBC consortium, the Strategic Commissioning

Director for the county council's adult social care services and the Director of Nursing/Assistant Director of Commissioning of the North East Essex PCT. This relationship was still developing when the evaluation began and the initial interview at the beginning of May was the first face-to-face meeting between all three to discuss the pilot. Similarly, the details of the pilot were still being worked up. This relatively early stage of development reflected several features of the local context and especially a recent history of organisational and financial turbulence, together with their consequences for inter agency relationships.

35) In October 2006, five new PCT's were established in the geographical county of Essex to replace the original 12. The Adult Social Care department also adjusted its structure to mirror the new NHS arrangements by appointing dedicated link managers for each PCT area. The new structures and personnel were still bedding down when the evaluation began and it was this factor which helped account for the early stage of development found in the pilot in May 2008. However, its influence was compounded by two other factors. First, the initiation of PBC had brought another set of actors and relationships into play. Again the PBC structure was still bedding in and the consortium felt it was still lacking in some of the infrastructures and support staff needed to fulfil its commissioning tasks effectively. For the GPs leading the consortium, the commissioning role- and its vocabulary- was new territory. Moreover, there were still uncertainties about the respective roles of the consortium and PCT, including their relationships with the 'constituencies' they served. A consequence of the introduction of these new NHS structures and relationships was that social care managers had experienced *'difficulties in knowing who to engage with'* though they thought front line relationships had been less disrupted.

36) Alongside the need to embed new structures, roles and relationships, were difficulties inherited from the consequences of the previous Essex County Council and PCTs' financial deficits. One casualty of these financial difficulties had been a collaborative care service which provided intermediate care in the home and which was delivered by an integrated team. However, the service was seen by social care to have been *'unilaterally withdrawn.....Both the commissioning arrangement and the integrated provision have gone. A lot of the drivers were around financial balance in the NHS.'* As a result, they were now trying to restore the longer term strategic vision which had suffered from financial 'short termism' and make up ground more generally. The greater involvement of GPs was seen as an added dimension which could assist in the task of re-building understanding and trust. The pilot was, therefore, an opening to re-establish a strategic approach, informed by evidence and front line expertise, working through new or extended networks of actors and agencies.

- 37) Intermediate care had been recognized as a development priority in the PCT's urgent care strategy and the PBC consortium had also identified it as a major work stream for 2006/07. GPs were said to have poor feedback from patients about existing care pathways, as well as unsatisfactory experiences, themselves. For example, difficulties were reported of trying to access services which operated in silos and were not available 24/7 while other resources, such as social care interim beds, were under-used. For the consortium, therefore, intermediate care was at *'the top of the list for improving patient experiences'*. It saw *'a big weakness of the current set-up that it is composed of historical components with fragmented access, incomplete availability by time and level, problems with capacity and problems with the integration of parts of the service and communication between them.'*
- 38) Social care recognised these difficulties but felt that intermediate care had been overly focussed on hospital discharge and re-ablement. It wanted to balance this emphasis with one on admission avoidance and case management because nationally as well as locally there was *'a lack of vision about where case management and social care fit around avoidance'*. In addition to its case management role for people who met its eligibility criteria, social care was also conscious that it had *'responsibilities to the wider population for prevention and, thus for intervening earlier in the pathway'*. From both health and social care perspectives, therefore, the pilot was *'an opportunity to have a blank sheet of paper and commission what will work and not be bound by what has historically been available.'*
- 39) From the outset, there was agreement that *'the project will be about the joint commissioning of an Intermediate care programme to avoid admissions'*. The first step in developing the pilot had been planned and a commitment to working across health and social care agreed: *'there is a stakeholder engagement event on the 16 May to look at the intermediate care pathway and how to reduce admissions – and how to work jointly. . We don't want to do it in silos'*. This event kick started the process of developing a vision for intermediate care and the re-design of care pathways. The pilot's objectives were subsequently defined as to:
- a) *Reduce inappropriate admissions to hospitals and care homes*
 - b) *Demonstrate how integrated PBC arrangements can reconfigure local resources to deliver locally sensitive services which are flexible to meet the future need Identify opportunities to increase choice and offer options for self directed care*
 - c) *Address the specific needs of people with long term conditions.*
 - d) *Change patterns of provision to deliver more care out of hospital*
 - e) *Empower carers and patients to access support services flexibly.*

It was recognised, however, that this agenda was a large one and might

need to be addressed incrementally by securing easy wins first.

- 40) There was agreement that these objectives should be pursued from a whole systems perspective in order to promote more patient/person centred pathways and produce better outcomes for people using services. The potential benefits from the pilot included:
- a) *The right care at the right time to maximise independence*
 - b) *Reductions in acute hospital and residential care admissions*
 - c) *Increased uptake of self-directed resources and exercise of choice (including, in health, people with long term conditions and predictable needs)*
 - d) *A single point of access through joint case management*

In addition to these improved outcomes and experiences for local people, both the NHS and social care saw organisational advantage from a whole systems approach to intermediate care. These included the ability to meet demographic pressures which threatened to make existing services unsustainable and the ability to use resources both more strategically and more flexibly.

- 41) Primary and social care participants had separately identified what was increasingly recognised to be a shared priority for a strategic shift of resources to community services. GPs in the consortium were said to be beginning to understand PBC as providing levers not only make a difference to individual patients but also *'to think about global shifts of care and shifts from the acute sector.....There is a hunger in primary care to provide more in order to retain resources which are flowing out of primary care currently.* Similarly, social care advocated such a shift in order to enable people to exercise a choice to stay at home and avoid admission either to hospital or to care homes. As Essex was an individual budget (IB) pilot, it was considering how self directed support would operate at the interface with the NHS in pathways for intermediate care. In addition, there was the beginning of recognition in both the PbC consortium and social care that GPs might use their own resources more flexibly to purchase non health interventions where these offered a more cost effective option. For the PCT, however, this approach was questioned as it appeared to be potentially a vehicle for cost shunting from local government to NHS budgets.

- 42) By January 2008, the pilot had made considerable progress compared with the position in May 2007. Admittedly, the new pathway had yet to be implemented and resources secured. However, the three sets of partners felt they had overcome many of the historical barriers they had inherited, albeit not without encountering some real difficulties along the way. A strong service development partnership had been forged between the GP leadership of the PbC consortium and senior management in adult social care based on a growing understanding of their respective roles,

resources and cultures. This development was described by one of the parties as a greater *'awareness of the range of services available outside your little bunker in general practice, things going on that you did not know about. So I'm signposting now. The opportunities presented to me are enormous.'*

43) The relationship with the PCT had been less easy at times. It had been central to the pilot at the beginning and was again so in January. Indeed, the PCT chair attended the group interview then. However, there had been a period when of *'really difficult discussions'* when the consortium felt the case for change and funding was not being adequately promoted. However, they managed to overcome these difficulties and *'suddenly everything fell into place'*. All three agencies agreed that they had succeeded in *'overcoming distrust from the past, getting over the previous mistrust of each other and moving on from a blame culture'*. Relationships between adult social care and the PCT had been re-built and social care was learning how to operate in and manage what was now a trilateral relationship for joint commissioning compared with the bilateral one previously. The PCT and the consortium had to develop their own relationships within the NHS as well as external relationships with local government. Most consortia, it was suggested (and regional experience confirmed), were focussed on purely NHS agendas and relationships; *'we are attempting something special here'*. Moreover, it was felt that whereas *'some PCTs did not know how to support PbC, the consortium (had) been well supported here'*. It had been more difficult, however, to engage with the main acute provider. Although they had had *'some success'*, the provider was seen to be concerned to protect its income stream and slow to appreciate that the pilot was *'an opportunity to refocus its business'* and an initiative which would help it achieve its 18 week target.

44) A substantial amount of work had gone into designing pathways drawing on evidence about need and effectiveness. Public involvement had been built into the process and social care had developed a strategy for synchronising its own IB based systems reform the redesigned intermediate care pathway. Clarifying the interface between individual budgets and intermediate care was an urgent practical concern and not merely a conceptual one. Social care was preparing to introduce IBs during 2008 for all service user groups other than mental health. The approach adopted was that all service users would not be charged for up to six weeks intermediate care and then receive individual budgets and/or a care package if they have an eligible assessed need at the end of a reablement process when their situation had stabilised and they had been empowered to self manage. At the service delivery interface, both social care and the PbC consortium had significantly better understanding of each other's ways of working and service systems. As a result, they could see the potential for better sign posting between services and better opportunities for accessing each others' services and adding to the range

of options each could offer those needing their support.

45) The outcome of the processes of visioning, pathway design and public engagement was a set of three business cases for the NHS local delivery plan (LDP) process and a set of social care proposals for the annual budget process. The LDP business cases comprised proposals for self care, care coordination and re-ablement. At the time of the January interviews, these funding bids were still awaiting approval and there was a ready recognition that *'we have not been anywhere near implementation yet'*. However, if they were successful in securing the necessary financial approvals, they were confident that they would move into the implementation phase within three or four months: *we will see the services coming through and especially some early wins'*. In addition, the synchronisation of the council's arrangements for self directed care with the jointly designed intermediate care pathways would represent a substantial platform for developing the integration of personalised commissioning in social care and PbC in primary care. The foundations for this approach were further strengthened from April 2008 when the new social care re-ablement service was launched. At same time, the PCT confirmed its strong desire for very close joint working including joint management and collocation of assessment and provider staff.

Suffolk

46) The project stemmed from wider systems reform initiatives developed separately by the county council and PCT, respectively. Although, a subset of two separate and bigger initiatives, it presented an opportunity to bring elements of them together within the framework provided by the LSP and LAA, to produce something greater than the sum of their parts. The pilot's focus was on developing an integrated service for adults, and their informal carers, with long term conditions and complex physical needs. The core of the pilot was *'a joint working model that seeks to deliver a co-ordinated, comprehensive, community based service for people.....with a long-term condition (and at) highest risk of a hospital admission. In essence, the system uses the inclusive 'virtual word' concept (Croydon PCT), to provide case management in the community'*. A further key element of the pilot was the development of individual health service level agreements to operate alongside social care individual budgets for people with long term conditions (see below).

47) The PCT saw the pilot as a means of involving the county council and its responsibilities for well-being into the NHS systems reform demonstration programme *'so that we can break down barriers and (jointly) manage the total spend'*. In its broadest sense long term conditions for adults was considered to be *'the business of everyone'* but there was perceived to be a risk that the agenda would be addressed separately. Thus the role of the pilot was seen as being to mitigate that risk by providing a focus for joint

working and a means of coordination with its partners. From the county's perspective, internal changes were also promoting new opportunities for collaborative working in this field. It was described as *'creeping towards a joint arrangement for long term conditions'* not least because the shift away from a client group focus in its own work was beginning to support a re-focus of its activities on long term conditions.

- 48) From the viewpoint of the wider local authority and its place-shaping responsibilities, the pilot's emphasis on establishing more community based systems and pathways provided potential benefits in terms of keeping people *'better connected in their communities'*. The place-shaping perspective was also consistent with, and reinforced the view that ready access to person centred services dealing with the full range of their needs was the priority for the residents of any locality: *'most people are not hung up on who provides but they do not want to be passed from pillar to post. Rather, they wanted 'holistic / integrated approaches with prevention built in'*. The pilot also aimed to provide local citizens with the tools to make more choices more effectively. The two principal tools were seen as increased control over resources and extended access to information. The first would take the form of individual budgets for social care and individual SLAs for health. The second would be the role of a web based information system in extending access a wider range of options which would include community sponsored activities as well as formal services.
- 49) On the local authority side, the pilot originated in a number of different but related work streams. These included the business process re-engineering work associated with a predicted shortfall of some £12 million for adult social care in the coming five years. One of the responses to this gap (and others) was to re-design the customer journey in partnership with BT (whose headquarters are located in the county). The county was putting all life-shaping services in one web-based system which covered sign-posting, brokering and arranging access to services. Libraries and their staff were to provide support in using this service.
- 50) The various components of this customer access and information programme included: *rapid access to assessment services; access to universal services; a comprehensive service directory (Infolink); assistive technology advice; and access to self assessment*. The Council had entered into a 10 year agreement with BT which had achieved £60 million savings in other services: *'so we are hopeful it can achieve savings in social care'* and particularly by *'taking around £1.2 million off demand by people being directed to other solutions'*.
- 51) The customer journey work *had 'not involved the active participation of health colleagues'*. Rather, the local authority had been *'sorting out the partnership with BT and some of the systems which will be used'*. By May 2007, however, the pilot was providing an *'opportunity to involve health'*

and it was soon agreed that the information package should include a professional service directory for health as part of the wider directory of statutory and community resources. In addition, it was anticipated that access to GP surgeries might be included later.

- 52) The position with Individual Budgets was not dissimilar. Although Suffolk was not a national pilot site for IBs, social care was very actively preparing for their introduction. The pursuit of this agenda was based on the belief that *'IBs and the wider vision of personal development that goes with it helps to move us out of the straight-jacket of professional control.....and to think exclusively in terms of citizenship'* In Suffolk there would not be *'a choice about whether to have an IB but a choice about whether you manage it yourself'*. Social care had initiated a work programme to identify the costs of all its activities so that, from 2008, users would be able to spend specified sums on different elements of care and support, including brokerage and the therapeutic role of social work. It was also hoped to include the adult learning, culture and other leisure services within this costing system, a process facilitated by their being located in the same department as adult social care. Indeed it was suggested more fundamentally that *'because we are now Adult and Community Services our thinking is now wider.....and it is about people and their needs as a whole'*.
- 53) Work was also being undertaken to develop *'an "IB ready" contracting culture'* and from 2008 it was planned that all in-house provider services would be hived off to delivery agencies (70% of services were already provided through the independent sector). There was also *'a desire to work out how IBs can work alongside devolved GP budgets as the NHS devolves down to individual patients'*. As with the work on access and information, however, the development of IBs had been an internal local authority initiative and NHS involvement had been minimal until the pilot was launched. Until that point, there had also been little if any movement towards the alignment of social care commissioning and PBC more generally: *'we have not jointly talked about it. The concept of IB is seen as equivalent to PBC. Its one of the issues to pursue in the project. It should help our conceptual thinking and getting the GPs on board'*.
- 54) At the outset, the partners in the pilot were the county council and PCT. Once the project plan had been approved by the pilot's steering group, it was expected that *'we will then get the GPs actively engaged'*. Nonetheless, the GP consortia were seen to have been instrumental in re-establishing joint commissioning as part of their pathway re-design role and their contribution was seen by both social care and the PCT to be growing in scale and value. In addition, the PCT wished to test individual SLAs for individuals with long term conditions. This objective to some extent mirrored social care's thinking about IBs. Its implementation would necessarily raise issues about the interface between individual SLAs and

IBs where individuals were eligible for both.

55) More generally, the PCT had been no less engaged than the county council in implementing internal systems reform and other agendas. Indeed, it was part of the DH led national health system reform demonstration programme. From the perspective of this programme, it was conceptualised as a vehicle for *'testing national health reform mechanisms by implementing them across the Suffolk system in order to improve care for very high intensity adult users of services.'* Thus, it constituted one work stream within a wider NHS initiative and was unique for its engagement of the council in its governance and delivery. Indeed, one of the explicit objectives of the work stream was to make *'the best use of joint working with Suffolk County Council and other partners'*. The range of areas to be explored included: *'Care Pathways, eligibility criteria, clinical/care specifications; Commissioning & Contracting (including Practice Based Commissioning); Governance; Finance (including individual finance & joint); Workforce, Education & Training; Information & data; Communication; Involvement/Empowerment/Choice; Assistive Technology'*. In addition, the pilot was designed to move adult provider services in the PCT through to a more independent status.

56) All these various activities were to be brought together in the pilot through three work streams *Customer Access and Information; Integrated Models of Care; and Individual Budgets*. In turn, the work streams were expected to secure improvements in five main sets of measurable outcomes:

- a) *Improved health and well being that support independence and increased quality of life.*
- b) *Responsive and accessible services that treat people with respect, and give users choice and control.*
- c) *Safe and effective services*
- d) *Efficient, affordable and sustainable services.*
- e) *Equitable outcomes and allocations.*

57) The objective of securing the engagement of PBC consortia was being achieved by the time of the January interview. Three of the eight Suffolk PCT consortia had agreed to participate in the pilot as had a consortium based in Waveney PCT (which covered areas of both Suffolk and Norfolk). Although entry to the pilot was on the basis of willingness to participate, the consortia covered a wide range of socio economic and geographical variables as well as different patterns of services. Each consortium would be focussing, in partnership with local authority services, on preventing hospital admissions and reducing lengths of stay for cohorts of high intensity users. Some 600 people in this category had identified by the PCT but the pilot then found that only 335 of them were also known to services. Subsequently they had asked participating practices to identify their top ten cases with intensive care packages across health and social

care who were willing to work with the pilot and who the practices thought might benefit from having an IB and an individual health LSA.

- 58) Public engagement was fundamental to the re-design of care pathways and was now in process through focus groups and other forms of consultation. One result from some of this work (especially in Waveney) was a strong preference for care closer to home and a growing recognition that hospital was for the very ill. Care pathways and associated clinical specifications were being worked up as a prelude to developing business cases and tendering them. Tenders would be whole system and outcome based. The new service specifications would be a lever to change the services of the PCT's provider arm and there had already been a lot of dialogue about care pathways with social care as well as community health service providers. The web based information system had been extended to include health resources, GPs were not yet using it as fully or extensively as they might.
- 59) The pilot had faced a number of challenges in progressing its objectives. One reported difficulty was the general experience of organisational overload in a context of managing extensive change agendas simultaneously with creating new structures. Suffolk PCT was established in October 2006 as a single organisation in place of five smaller ones. It was also dealing with a legacy of substantial deficits, though it was expecting to achieve an in year balance. The local authority was also not immune to the effects of potential and actual restructuring. During the period of the pilot, Ipswich District had applied for unitary status and, although initially unsuccessful, the issue was not closed. Internally, the social services department had been disaggregated into separate children's and adults sections which, in turn, had been combined with education and community services, respectively. Of even more fundamental importance was creation of a matrix structure for the county council as a whole with effect from April 2008 with the result, for example, that social care commissioners were located in a unified, generic commissioning function which worked across all service areas.
- 60) The creation of a single Suffolk PCT had the potential to create a significantly less complex environment for joint working with the county council (though the existence of Waveney meant that coterminosity was not complete. NHS re-structuring had inevitably caused discontinuities in organisational relationships and an internal focus in the NHS on establishing new roles and responsibilities. Moreover, past relationships between the NHS and local government had not been the best. Both services agreed that Section 31 arrangements had *'not been successful.....and in the past we struggled'*. In January 2008, they described *'joint working as having been in deep freeze for two years'*. They were having to overcome *'a sense of disillusionment.....(and) it was difficult to start all over again...we have had to believe that this time it (joint*

working) will influence something and make a difference.'

- 61) The pilot was, however, seen as an opportunity to work differently together. If this background meant that progress was initially slow, the pace of progress appeared to be increasing though the legacy of previously disrupted relationships had not been completely spent. In addition, capacity continued to be stretched thinly or focussed on meeting other demands. Dedicated project management support was seen as a potential mechanism for overcoming these capacity constraints. Despite these challenges, however, there was confidence that new care pathways would be being implemented by the end of 2008.
- 62) Indeed, between January and April 2008, the pace of development accelerated and further progress was reported in a number of respects:
- a) An outcomes framework had been developed incorporating QUALYS and the EQ 5D tool
 - b) 20 assistive technology systems had been procured and the pilot was working with a number of small rural practices to identify patients with COPD and heart failure with whom to pilot the systems
 - c) The majority of design work for the five PBC pilots in different parts of the county had been completed, including the involvement of social care staff. An additional by product of working with social care had been that NHS thinking had shifted towards adopting the developing social care way of working. Thus the focus with the integrated teams had moved away from long term interventions to shorter term interventions, with patients then being referred on to appropriate services for their long term management.
 - d) As part of the pilot's focus on developing case management, it had produced a set of competencies incorporating previous local and national work. The underlying philosophy was that all professionals working with people with long term conditions should have a generic/transferable set of case management skills backed up by "can do", solution focused attitudes among all of those working with people with long term conditions.

Principal Findings

- 63) It was previously suggested that the collection and analysis of data could be structured around two frameworks: the *outcomes, focus, infrastructure* perspective into which were organised the aims and objectives of the call for expressions of interest; and the eight steps for effective commissioning contained in the draft guidance on commissioning health and wellbeing. These frameworks drove the design of semi structured interview schedules, 'internal' presentations and discussions at network meetings and the invitation to those meetings of external speakers on, for example, self directed support and a joint performance assessment framework. In

the first instance, therefore, the experience of the pilots will be reviewed within the *outcomes, focus, and infrastructure* framework and with particular emphasis on seeking to understand the observed and reported patterns of individual and process outcomes.

- 64) Implicit in the initial call for expressions of interest was the assumption the successful projects would deliver services leading to observable outcomes by the end of the pilot period (initially December 2007 and subsequently April 2008). The pilots were volunteers and it may not have been unreasonable to expect that they would be relatively advanced in their thinking, development and relationships. In practice and with hindsight, however, CSIP and the pilots have recognised that this expectation was unrealistic given the combined legacies of the past and challenges of the future which all sites experienced in varying degrees.
- 65) To suggest that the pilots could not have performed more effectively would be lacking in all credibility. Nonetheless, it should be recognised that the network was established as a focus for learning and development, not for performance management. Its aims and ethos were oriented towards providing a safe environment for individual and collective learning. The evaluation was also commissioned as part of the same learning process. It has necessarily identified differences in the extent of implementation and in ways in which pilots met their particular challenges. However, such findings are seen here as precisely differences which may merit explanation but which are not the basis for comparative judgements about performance.
- 66) Moreover, such differences are better understood as the product of variations in context rather than performance at this stage in the evolution of relationships between PBC and social care commissioning. Not only was the starting post for all three pilots too far back to reach a finishing post where re-designed services could deliver planned outcomes; the three starting posts were also at different points on the course. To risk overextending the metaphor, the sites could be seen as not only carrying different handicaps but also having different numbers and heights of hurdle to jump before they could successfully deliver re-designed services to their local residents. It is also worth noting that their current positions in the field may not accurate predictors of their finishing places when they complete the final furlong.

User outcomes

- 67) In what follows, the discussion of outcomes is organised around two dimensions: those relating to process and those relating to health and wellbeing for individuals, their informal supporters and the communities in which they live. This latter group of interdependent 'end user' outcomes will provide the basis for final judgements about the impact of the pilots in

terms of independent living, choice, control and related values. In practice, however, this outcome dimension is, as yet, barely relevant to the pilots except at the level of intent. As the summary case studies have indicated, while maximising such outcomes through locality commissioning was the central purpose of each pilot, April 2008 was simply too early for such impacts to be evident.

68) Only Hertfordshire had new care pathways in place and people moving along them. Even there, the pathways had not been extended to all practices and social care mechanisms for self directed support were still to be fully operationalised and integrated with the re-designed care pathways. Essex had submitted business cases to fund the re-designed intermediate care pathway and, in January 2008, expected them to begin coming on stream in the spring and being used by significant numbers of people by the end of the calendar year. Suffolk expected in January 2008 to have new pathways beginning to come on stream by the end of the year and being used by March 2009. If one allowed a follow up period of only six months before assessing outcomes, such evidence for even the earliest cohort of service users would take correspondingly longer to become available. One vehicle for enabling the pilots to gather such data as quickly as possible was the commissioning by CSIP of UEA to work with sites to develop appropriate instruments ready for use when the new services began.

69) An initial finding, therefore, is that the pilots were yet to have direct, measurable impacts on their local populations and communities. If, however, the slow take up of change can sometimes be explained by an unwillingness to innovate or a lack of commitment to carry it through, neither factor was evident among those with direct responsibility for the pilots, (though they were sometimes factors elsewhere in the local care economies). The pilots were volunteers and strongly committed to achieve their objectives and it is reasonable to look at the influence of other factors, therefore. In particular, the nature of the implementation task and the context for implementation were such that any other result in terms of user outcomes within the timescale of the evaluation would have been so remarkable as to be improbable.

70) The pilot sites were successful within the evaluation time frame in achieving a number of process outcomes, however, meeting substantial challenges en route and laying the foundations for services which, the literature suggests, have the potential to deliver significantly different 'final' outcomes for local people. One lesson underlined by the pilots' experiences is that their policy, implementation, delivery chains were highly complex and their links difficult to forge; nor did they exist in a vacuum. Rather, they operated in an environment of considerable complexity and change: an environment which created barriers as well as opportunities for the pilots while also absorbing resources,, which might

otherwise have been devoted to them. It has long been suggested that central government, including DH, gives insufficient attention to the implementation of policy. (Challis et al 1988). In practice, it may be argued with some justification that implementation support has become more substantial, not least through the work of CSIP. However, the pilots' experience suggests that there may still be a tendency to underestimate the combined impact on local capacity of the full range of national initiatives with which local actors are dealing at any one time. Certainly, the developmental paths of the pilots seemed to be heavily shaped by the volume and consequences of previous and current initiatives as much as by the objectives and delivery mechanisms of the pilots, themselves.

Process outcomes

71) The learning network provided an opportunity and framework to develop relationships and understandings across the interface between primary care and social care commissioning and in the midst of much complexity and change. The summary case studies demonstrate that their overriding purpose was to improve user experiences and outcomes by promoting more independent living, choice and control. The extent to which each site was immediately able to take advantage of the opportunity to enhance outcomes was understandably influenced by their respective histories of joint working. At the outset, the recent re-structuring of the NHS meant there was much ground to cover in both Essex and Suffolk. The new PCTs were still bedding down and only beginning to develop a stronger external focus. Appointments were still being made and former collaborative relationships needed to be re-built. Indeed, local authority staffs were sometimes still unclear about the new patterns of responsibility in the local NHS and with whom they should be seeking to engage.

72) None of this should be surprising. As Field and Peck's review of literature on organisational mergers, concluded: '...strategic objectives are rarely achieved, financial savings are rarely attained, productivity initially drops, staff morale deteriorates, and there is considerable anxiety and stress among the workforce.' It is difficult to continue with 'business as usual' while building new organisations, fostering new relationships and re-building trust. Similarly, the literature on partnerships emphasises the critical importance of mutual understanding, confidence and trust based on long term, continuous relationships. In both respects, the starting point for the Essex and Suffolk pilots was one of re-establishing collaborative relationships and structures often with delays while new players came into post. Indeed, the pilots contributed to the re-making of PCT and local authority relationships in both counties. The impact of re-structuring was, however, weaker in Hertfordshire. The amalgamation of PCTs into two bodies with a single management team at the county level effectively met up with an established joint commissioning team operating at the same level and which was able to continue in its role with minimal disruption to

its activities in the mental health field. In all three sites, however, the emergence of PBC consortia was turning traditionally bipartite commissioning structures into tripartite ones. As a result, all parties had additional and substantially unknown sets of relationships to negotiate and navigate. In particular, the consortia were still establishing their scope for autonomy and discretion in relation to PCTs and, as entirely new organisations, had, by definition, few established networks with social care on which to build.

- 73) Moreover, the pilots had been set up to focus on the interface between primary and social care commissioning precisely because relationships, understandings and service delivery were underdeveloped at that point in NHS and local government systems. In effect, the pilots were required to develop as well as test out the capacity and capability of tripartite joint commissioning relationships in a context where critical lubricants of partnership working - mutual confidence and trust – had still to be applied. In addition, these consequences of organisational discontinuity were compounded by the handling of financial deficits in the NHS. On some occasions, this had fractured in the relationships with councils (the financial deficits inherited by the new East of England SHA were among the highest in England). For example, local authorities had experienced what were described as *'unilateral cuts'* to joint services and again, trust needed to be re-built by the incoming organisations. The need to give top priority to financial recovery also meant that resources for funding the pilots' re-designed care pathways were also very tight.
- 74) Further complications and challenges arose from the wider change agendas of which PBC and self directed support were a part. In effect, the pilots were operating at a point where systems reform in the NHS intersected with systems reform in social care and local government. While both were part of a wider movement for public service reform and the transformation of government, they were also the distinct product of the values and of each service. Self directed support in social care had quite separate origins from practice based commissioning and other aspects of the market-like reforms being introduced in the NHS. Such cultural differences were highlighted by a GP in one of the pilots who commented that he *had 'had to become proficient in three new languages, first the language of DH, then of the PCT and now of social care'*
- 75) Those differences in the language of health and social care, respectively, can be illustrated by the following sets of sometimes overlapping but fundamentally different approaches
- a) self directed support and expert patients;
 - b) personal-budgets for individuals and indicative budgets for GPs;
 - c) choice and control or choose and book;
 - d) tightening eligibility criteria and treatment for all within 18 weeks.

76) In addition, relatively little attention was given to the interdependencies between the two sets of systems reform initiatives at the time they were conceived and developed. The initiatives on commissioning for health and wellbeing, on the one hand, and world class commissioning, on the other provided prime examples of such largely separate developmental processes. The new local performance framework and LAAs which flowed from the 'Strong and Prosperous Communities' White Paper potentially ~~did~~ offers an overarching structure within which both sets of reforms might be coordinated but it was launched after the pilots began and was little help in terms of integrating the nuts and bolts of the different systems reform agendas.

77) The consequence of these of these change programmes for the pilots was two fold. First, they were implementing systems reform in their own organisations while simultaneously seeking to join up locally with similarly far reaching changes in partner organisations. Second, the task managing both the internal and external challenges posed by separate systems reform programmes inevitably stretched capacity thin, especially when posts were still being filled. Such pressures were reflected in two kinds of comments in the group interviews,⁷ the first suggesting that the pilots presented complex challenges *'on top of my day job'* and the second noting that alongside the pilot, *'there's everything else coming down the road at us'*. Again the continuing capacity provided by dedicated joint commissioning posts in Hertfordshire contrasts with the picture elsewhere.

78) These pressures and challenges were, of course, 'merely' a contemporary overlay on the longer term weaknesses of commissioning in general, joint commissioning more specifically and the engagement of GPs in jointly re-designing services most particularly. Seen from this perspective, the pilots were a remarkably ambitious initiative. They were also, in many respects, very successful ones. Each proved able to maintain a person-centred focus to commissioning and pathway design. Two had largely completed the latter process between April and December 2007. The third, which was covering by far the widest geographical area and range of pathways, expected to reach that point in the summer of 2008 and appeared to be catching up fast by the spring of 2008. Two had secured GP engagement from the outset as real and not token participants in the re-design process. In the third, the PCT and local authority concentrated on re-building their own relationships initially but GPs had become more fully engaged and PBC consortia were now integral to the pilot's developmental process. All three had shown a commitment to evidence based commissioning, obtaining additional evidence about need, where necessary, seeking out the knowledge base for different interventions and engaging the public more fully.

79) Participation in the pilots was also widely credited with promoting learning,

especially between general practice and social care. Participants from both backgrounds described how they had come to understand each other's systems and the opportunities or constraints associated with them. They had learned more about what each could offer the other and their respective service users. As a result, they had come to recognise their mutual interest in commissioning care closer to home and in combining resources to provide more appropriate and holistic care. The joint development of care pathways and associated business plans was evidence that this shared interest was being recognised and exploited. The pilot process thus provided opportunities for the emergence of champions of closer working between primary care and local government and alliances were being formed across that interface. This development helped challenges to be addressed positively, energetically and persistently.

80) In addition, GP leads reported that their engagement had led to changes in their personal practice, partly as a result of increased knowledge of what local authority and community resources could offer their patients. More fundamentally, they were also developing better understandings of psycho-social models. One provided an example of being called to visit a young person with severe disabilities. After some lengthy discussion, he realised that the underlying reason for the requested home visit was the social isolation and loneliness of the mother. He also saw that her needs would be better met by the community networks and resources he could now access through the council rather than by prescribing medication. Thus, involvement in the pilot was leading him to add social prescribing to the menu of options he could offer his own patients.

81) Not all aspects of the pilots were so successful. In particular, there were some difficulties around funding and provider issues. For example, the original intention to devolve an integrated health and social care budget to the Stevenage consortium to commission mental health services was not realised within the period covered by the evaluation. However, the Hertfordshire pilot was able to de-fuse potential opposition to service re-design from its provider by guaranteeing the latter's income for three years to enable it to redeploy resources and staff to the new service model. A competitive tendering exercise was to be carried out at the end of this period.

82) In Essex, the PBC consortium and adult social care partners initially experienced significant difficulties in their funding negotiations with the PCT and their relationship with it was not an easy one at first. However, it subsequently became clear that the consortium had not fully learned how to use the processes for making business cases. Once this was appreciated, there was *'an epiphany and everything has gone well since'* (as reported at the January 2008 interview). At that time, responses were awaited, to three business cases submitted through the LDP process. The

PCT was openly supportive of the project and the PCT chair attended the January interview. The attitude of the main provider was, however, reported to be one of perceiving the re-designed intermediate care pathway as a threat to its business. The pilot's view was that the new pathway should be supported not only because it offered a better patient experience but also because it would assist the trust in meeting its 18 week target. By contrast, the Suffolk pilot had, in January 2008, still to reach the point where relationships with provider interests presented such immediate implementation challenges. One reason was that a judicial review was being undertaken a proposed hospital closure. Nothing could be done which gave any impression of a withdrawal of services and pathway re-design was 'on ice' in that part of the county.

83) These experiences in Essex and Suffolk underlined the extent to which provider and public support for service reconfiguration are critical to successful pathway re-design (very similar issues arise in relation to the impact of personal budgets in social care). Darzi has since sought to give re-assurances to the public about NHS reconfigurations having to be justified by evidence of better outcomes and new services being in place before existing ones are withdrawn (REF).. The Hertfordshire strategy of commissioning the existing secondary provider to re-configure its own services within primary care settings largely avoided such tensions, if only for the three years before the new service was tendered. However, as this discussion indicates, at least some element of decommissioning is the logical consequence of service and pathway re-design. Yet, it is an aspect of the process which has received relatively little attention in official guidance such as the framework for commissioning health and wellbeing.

84) In the main, the pilots did not yet have practical experience of adopting new financial mechanisms across the primary and social care interface. Hertfordshire and Suffolk adult social care were not national pilots for individual budgets but were engaged in their own development and piloting work for roll out in 2008/09. Essex was a national pilot and was proactive in synchronising its planned extension of IBs to older people in 2008/09 with the requirements of the re-designed intermediate care pathway. On the health side, Suffolk PCT was developing Health Service individual SLAs for testing alongside IBs as part of the national systems reform demonstration programme, These SLAs were still at an early stage of planning in January 2008 but the pace of development was accelerating by the spring and Darzi's support for IBs in health seemed likely to reinforce such initiatives (REF)

85) However, none of the sites was taking advantage of the flexibilities which allowed GPs to use NHS resources for '*non-health interventions*'(Ref) The possibility was raised in one of the site interviews and led to an interesting exchange between PCT and consortium representatives. The latter supported their adoption from the perspective of a clinician wishing to give

patients access to the best and most appropriate options to meet their health needs. The PCT was resistant on the grounds that it would be wrong to use 'health monies' to subsidise other agencies' services. For the clinician, this view was irrelevant compared with the over-riding priority of ensuring patients received the best care possible.

86) It is now possible to summarise the above findings in terms of the *outcomes, focus, infrastructure* framework derived from the initial call for expressions of interest:

- a) The pilots clearly articulated the *outcomes* they were seeking to attain on behalf of local people. While it was too early for differences in such final such outcomes to have been delivered in the three sites, the pilots had been clearly successful in delivering important process outcomes (re-building relationships, mutual confidence and trust, for example).
- b) The main *focus* of their work was and remained that of re-designing services and care pathways. They did not get allow the design of cross agency structures and mechanisms to become ends in themselves.
- c) Many of the process outcomes can be seen as the 'softer' elements of the infrastructure necessary for joint PBC and social care commissioning. Progress was also made in using and developing the relevant evidence bases. However, there may be scope for greater integration of the pilots in mainstream decision making processes.

Commissioning for Health and Wellbeing

87) The consultation document was published as the pilots were getting underway. It was accepted as a framework relevant to their work and for assessing which if any of its eight steps to effective commissioning were helpful to it. The initial interviews and network meetings demonstrated that the draft guidance had made a very favourable impression: a not untypical description was that it represented '*one of the best things to come out of the Department of Health in years*' (This positive endorsement was also very widely reflected in the responses to the document-see DH 2008b). In what follows findings from the evaluation are interpreted in relation to three of the eight steps which were most relevant to the pilots given their stage of development.

Person Centred Commissioning

88) The pilots provide clear examples of commitment to develop the person centred approach to commissioning advocated in the 2007 draft commissioning guidance on health and wellbeing.

- a) The most powerful starting point for and driver of the pilots was recognition of the need to improve outcomes for actual or potential users of services and their informal supporters.

- b) This recognition was, moreover, shared across social care, PCT and PBC stakeholders and accompanied by a commitment to secure better outcomes for local people by working together, rather than separately.
- c) In each pilot, people centred outcomes were articulated in terms of independent living, choice and control across all aspects of an individual's life and relationships.
- d) Each pilot drew on and/or developed arrangements for public involvement which helped shape understandings of need together with the design of responses to it.
- e) The principal focus of commissioning activity was to design service systems and care pathways so that needs could be better met, experiences of services receipt improved and outcomes enhanced.
- f) Joint commissioning and other interagency mechanisms were regarded, in practice as the means to achieve the outcomes identified, to design the services required and to deliver the pathways agreed. Compared with previous experience, there was very little emphasis on joint commissioning structures and processes as ends in themselves.

Evidence Based Commissioning

- 89) The pilots were underpinned by data on need and evidence about the effectiveness of service design and delivery:
- a) Each locality was in the process of developing its Joint Strategic Needs Analysis and this provided a context for the pilot work
 - b) Each of the pilots was seeking to understand better the extent and structure of needs and service use by the re-analysis of current data and use of instruments such as PARR
 - c) One locality commissioned user and carer groups to carry out surveys of need and complement information about needs and activities abstracted from regular information collections and patient records.
 - d) In some cases, literature searches were instituted and evidence based service components and models were identified (especially in Hertfordshire where a nationally and locally tested model was the basis for a re-designed care pathway). Elsewhere, evidence from NSF's provided the foundation for different aspects of re-design (for example older people and neurological conditions)
 - e) Two of the pilots had pre-existing protocols for information sharing at the individual level. Its absence in the third necessitated time consuming negotiations and, at one point, was a constraint on the pace of progress
 - f) Each site was proactive in identifying and utilising an evidence base for re-designing services and care pathways, conscious that both commissioners and providers would be reluctant to release resources in its absence

Incentives for commissioning health and wellbeing.

- 90) The incentives identified by the draft guidance for commissioning health and wellbeing included: *'using Local Area Agreements; using contracts; pooling budgets; and using the flexibilities of direct payments and practice based commissioning.'* The same document also noted that Incentives and funding routes within commissioning systems *'do not yet fully support the delivery of better health and well-being.'* In practice, the experience of the pilots suggested a complex balance of incentives and disincentives in each site acting with varying degrees of strength as levers for or barriers to change.
- a) The improvement of user outcomes and experiences was itself, a powerful incentive for developing and sustaining the joint pilots. The policy emphasis on the values and principles of independent living, voice, choice, control and care closer to home seemed to be powerful in creating shared visions between the NHS and local government to drive service design and commissioning.
 - b) Such shared values and principles were further reinforced by the experience of working together.
 - c) The existence in Hertfordshire of a formal set of joint commissioning structures, processes and officers greatly facilitated the work of the Stevenage pilot, as did the joint budget and integrated service for mental health.
 - d) This Hertfordshire experience underlined the barriers created elsewhere by the previous breakdown of or discontinuities in health and local government relationships. However, in Essex and Suffolk, recognition of the need to re-build them to achieve the joint vision was itself, an incentive to overcome barriers located in local histories of interorganisational relationships.
 - e) All of the sites had joint agreements of some kind, including the project initiation documents and agreements with CSIP to participate in the learning network. Such agreements operated within the collaborative contexts of wider LSP/LAA frameworks, which was a particularly active influence in Suffolk.
 - f) Membership of the CSIP network was also identified by pilots as having incentive effects. These included the ability to share experiences with others, the perceived pressures to succeed alongside peers and the combination of spotlight and halo effects which accompanied pilot status.
 - g) While the pilots were undoubtedly value and outcome driven, other factors were also influential motivations, even if of a secondary nature. The prime examples were the perceptions of demographic and financial imperatives to work together to change pathways. As one respondent emphasised, if service patterns and practices were not radically modified in the face of such pressures *'we are all lost'*.

Joint Commissioning for People and Systems

91) Commissioning takes place at different levels in the policy-delivery chain.. Most of the pilots' activities thus far have been conducted at the PCT and local authority strategic commissioning level where the re-design and procurement of pathways and services takes place. PBC consortia are a new and additional partner at this level. The pilots suggest there are real benefits to be derived from securing their engagement in joint commissioning. As they become established more attention should be given to supporting that engagement and to consolidating the new tripartite relationships with PCTs and local authorities.

92) The concept of a multi levelled set of commissioning processes is also helpful in clarifying the need for integration between whole systems and whole person commissioning. Thus better outcomes for individuals depend not only on the design of integrated care systems and pathways but even more crucially on the integration of service delivery around the needs and choices of individuals. The link between strategic and individualised commissioning (sometimes referred to as macro and micro commissioning, respectively) has not always been well-developed. In addition, the introduction of personal budgets is sometimes seen as a challenge to the continuing role and purpose of strategic commissioning. Indeed, the journey to self directed support is, from a whole systems commissioning perspective, one into relatively unknown territory as the implications for supply of individualised demand become more apparent. This tension is, of course, to be expected since one of the underlying purposes of personal budgets and other mechanisms for self directed care is to make demand more effective at the individual level. and thereby, drive if not bypass traditional forms of strategic commissioning. The degree of fit between more effectively expressed bottom up demand and established top down supply systems should, therefore, become more transparent. This dimension of the relationship between strategic and individualised commissioning was beginning to become apparent in the relationships between pilots and providers.

93) Historically, the strategic and individual dimensions of joint working have been dealt with through the distinct mechanisms of joint commissioning at the macro level and multidisciplinary teamwork (or less structured forms of collaboration between professionals) at the micro level. In effect, the latter allocated services and support which had been pre-purchased at the strategic level. The introduction of personal budgets and other forms of self directed support is intended to shift purchasing power to the individual level. It is also intended to enable the more flexible spending of those budgets on a wider range of services so that needs can be met more holistically. This is not to say that multi disciplinary teams are no longer required but they will have a different relationship with users through the 'up front' allocation of resources and the wider repertoire of interventions

and support that will become available as pre-payments come to an end or are significantly reduced.

94) From this perspective, the integration of PBC and social care commissioning through the pilots was intended to strengthen commissioning at both the strategic and individual levels. The first has been the customary terrain of joint commissioning, though PBC provides an added dimension and perspective to an activity in which GP engagement had not been commonplace. A further difference between traditional whole systems joint commissioning and that developing through the pilots was the focus on care pathways as the unit for service re-design within a whole systems perspective. Local authorities had not previously seen care pathways as an appropriate currency for re-design not least because adult social care has tended to experience the approach as starting too far into the acute phase of treatment and being centred on hospital throughput. Increasingly, however, as the Essex and Suffolk pilots illustrate, adult social care had begun to accept *pathway planning* as a useful vehicle for strategic re-design based on meeting individual needs across the health and care system as a whole.

95) It is necessary, however, to re-conceptualise care pathways as '*end to end*' or '*home to home*' *pathway planning* to maximise this contribution to joint commissioning at and between different levels of the policy process. The concept envisages that whole systems commissioning:

- a) starts with individuals living independently in their communities with high levels of health and wellbeing ,
- b) sees them protected from risks to the continuation of that situation
- c) provides support, treatment and care as close to home as possible when they are exposed to those risks
- d) supports their subsequent resumption of independent living and integration in the life of their communities as quickly and as fully as possible

96) Thus home to home pathway planning extends joint commissioning between health and social care to primary care, public health and the corporate responsibilities of local government for wellbeing, social inclusion and sustainable communities. Integration at the 'whole person' as well as whole systems level requires managing the interface between different approaches to the devolution of purchasing power by and on behalf of individuals. While they were not at a sufficient level of readiness to adopt them as part of the pilots in 2007/08, Hertfordshire and Suffolk were preparing to introduce IBs during 2008/09. For a small number of cases eligible for both social care and health care, Suffolk was also seeking to integrate social care IBs with 'individual health SLAs'. Essex had worked during 2007/08 to synchronise its IB arrangements with the demands of the new intermediate care pathway. It believed it had

succeeded in achieving the necessary synchronisation and IBs would be part of the pilot when it moved into a whole person joint commissioning phase.

97) Conceptually, the joint commissioning for whole systems and whole people can be summarised as follows:

- a) *Whole systems joint commissioning* at the strategic level based on end to end pathway planning and other forms of service design and re-design. From a PBC/social care perspective its critical feature is that it is a tripartite process. Its underlying philosophy is to support independent living and the exercise of choice and control within inclusive communities.
- b) *Whole person joint commissioning* through which individuals and their carers exercise choice and control over their support, treatment and care. Whole person joint commissioning can take at least the following forms:
 - i) Social care IBs² integrated/aligned with 'mainstream' NHS forms of assessment and case management
 - ii) Social care IBs integrated/aligned with 'GP flexibilities' to commission 'non health interventions' and create an actual or virtual joint resource allocation
 - iii) Social care IBs integrated/aligned with NHS IBs (known as 'patient held budgets' in East of England SHA) to create an actual or virtual joint resource allocation
 - iv) NHS IBs integrated/aligned with traditional social care forms of assessment and case management

98) The challenges involved in managing the interface between these different forms of whole person commissioning and resource allocation should not be underestimated. Even before the planned national roll out of social care IBs, there is evidence of difficulties at the interface between direct payments and NHS continuing care. The evaluation of the national IB pilots will, no doubt, report on whether any difficulties have been experienced at the interface with the NHS, including the predictions that the choices they open up will lead to cost shifting between NHS and social care budgets. It seems clear that the integration of social care IBs with standard forms of NHS resource allocations through primary care and community health services will need careful and proactive management.

² Technically a social care only IB is termed a 'personal budget' (PB) and the term IB should be reserved for budgets in which social care and other resource streams are combined. As this distinction was post dates the initiation of the pilots, and for the purposes of simplicity, the term IB is used generically here to cover all such possibilities

99) Moreover, the management of this interface will have to be addressed everywhere as councils gear up to make some form of up front individual resource allocations or budgets by April 2009. In some parts of EOE, the roll out of IBs, and hence the need for management alongside traditional forms of NHS assessment and case management, will be almost immediate. In addition, the opportunities presented by integrated resource allocations (whether real or virtual) will need proactive development and management.

100) The three pilots will increasingly be tackling some of these interfaces as they move into their whole person commissioning phase. They have already made significant progress in addressing long established barriers to strategic joint commissioning. They now have the opportunity to integrate those developments with the enhancement of choice and control across the health and social care boundary

Conclusion

101) The pilots have participated in a journey towards locality commissioning for improved health and wellbeing outcomes through whole systems re-design and the personalisation of service delivery. A number of features of that journey can be highlighted from the sites' most recent updates:

a. *The end of stage one is in sight:*

- i. By March 2008, they had made substantial steps towards completing the first of two phases of joint commissioning: the strategic whole systems level of pathway and service re-design
- ii. Aspects of phase one were still under development, including finance and the integration/alignment of devolved purchasing power
- iii. Phase two, implementing whole person joint commissioning had yet to begin but the sites were increasingly confident that they had laid promising whole systems foundations in phase one

b. *Progress has been less rapid than initially anticipated:*

- i. In effect, the sites had to reach base camp before they could begin their journeys
- ii. The impact of re-structuring and financial deficits had disrupted previous relationships and considerable efforts were required to re-build them
- iii. Effective partnerships depend on trust and continuity of relationships, two characteristics NHS and local government relationships which have been most challenged in the recent past

- c. *Joint commissioning was but one of many demanding journeys the sites were called on to undertake simultaneously*
- i. Both the NHS and local government are engaged in far reaching systems reform as part of the transformation of government agenda.
 - ii. Internal organisational demands tended to take precedence over re-building external relationships, especially in circumstances where capacity was stretched.
 - iii. Systems reform in the two services has some common starting points and destinations. However, key initiatives have been designed separately from each other and reflect their different culture, thereby adding to the barriers locality joint commissioning must overcome
 - iv. Self directed support and PBC were largely untested and under-developed aspects of systems reform. It has been necessary to understand and overcome the challenges they present each system before opportunities at the interface between them can be fully realised.
- d. *Systems reform also creates opportunities for new approaches to locality joint commissioning:*
- i. The NHS and local government seem to be oriented to a similar journey and destination, independent living based on health and wellbeing, choice and control
 - ii. The wider corporate responsibility of local authorities for promoting health and wellbeing in sustainable communities (including leadership of LSPs and the new LAAs) contributes to reaching that destination, as does the emphasis on primary care and public health in the NHS
 - iii. Although PBC is still developing, the contribution of primary care to a new tripartite joint commissioning partnership is showing real potential in more integrated pathway and service re-design as well as more integrated responses to need at the individual level.
 - iv. A key interface between self directed support and PBC is the point where the individual systems commit funds to individual people. Managing this interface creatively is a major opportunity to deliver holistic care and support based on choice and control
 - v. The national roll out of individual budgets (social care) creates incentives for innovation in joint commissioning at the micro (individual) level including its alignment with PBC flexibilities throughout the country and with patient held budgets in EOE

102) The pilots were poised to embark on a second stage of development and implementation that could see the achievement of significant enhancements to micro level joint commissioning. Some of the key lessons from that journey are summarised in Figure 2 'Lessons Learned'. In addition, further rounds of interviews in September and December/January will reveal how far they have been able to build on the foundations described here and begin to make significant differences to the choices and opportunities of their local populations.

Figure 1: Aims and Objectives of Pilot Programme

Commissioning for Needs and Outcomes

- 1 Addressing the specific needs of people with long term conditions.*
- 2 Identifying opportunities to increase choice and for more people to take up options for self directed care*
- 3 The pilots will offer opportunity for local innovation and leadership in developing models for effective, responsive local commissioning, supporting people in the context of their families and communities..*

Commissioning Focus

- 4 Demonstrating how integrated PbC arrangements might reconfigure local resources to deliver better and more locally sensitive services which can be more easily adjusted as required into the future*
- 5 Developing model plans for local changes in provision and in structures, systems, staffing, skills and workforce of existing providers.*
- 6 Changing patterns of provision to deliver more care out of hospital*
- 7 Improving access and out of hours care*
- 8 Developing joint approaches to promoting developments in health and wellbeing services*
- 9 Opportunities for market development and review of commissioning/procurement with voluntary and independent sector providers.*

Commissioning Arrangements and Infrastructures

- 10 Identifying the evidence base to inform the commissioning of effective care.*
- 11 Examining the workforce issues related to effective commissioning to support efficient & effective practice, new roles and new ways of working.*
- 12 The pilots will offer local models of partnership arrangements; governance structures; structures for local decision making and performance reporting/monitoring. Opportunities to review issues relating to eligibility and charging*
- 13 There will be learning in terms of the needs analysis, financial analysis and activity data required to support local commissioning*
- 14 Development of models for local investment which are financially sustainable i.e. re-investing savings from reconfigured services or agreeing priorities for use of pump-priming or transitional monies, but not dependent on new investment.*
- 15 Opportunities to incorporate new (consultation) guidance on joint commissioning (Dec 06/Jan 07) into practice and to explore anticipated greater financial flexibilities across health/social care*
- 16 Opportunities to develop models for evaluating pilot outcomes and for user/carer involvement*

Figure 2: Learning Points

1. Influence of the Past

- a. The path towards the integration of NHS and local authority commissioning was dependent on local contexts and histories
- b. Its foundations were those of mutual confidence, trust and understanding which, in turn, depended on some degree of continuity in organisational and personal relationships
- c. Where core organisational deliverables depend on external as well as internal relationships, the impact of such discontinuities should be factored into the case for reorganisation and its implementation.
- d. Restructuring drew organisations into a period of inward looking activity, fractured established relationships and disrupted many (but not all) external partnerships for commissioning and service delivery
- e. These consequences were predictable and should be an essential focus for post re-structuring development programmes and the setting of realistic delivery targets
- f. In this context, an initial emphasis on basic process outcomes was a necessary pre-condition for working towards user outcomes

2. Understanding the Task

- a. PBC and social care commissioning are, as yet, imperfectly understood and relatively underdeveloped aspects of systems reform which have been initiated separately within the NHS and local government, respectively.
- b. It has been necessary to understand and overcome the internal challenges each presents their own system before opportunities at the interface between them can be fully realised.
- c. The pilots sought to join up 'on the ground' separate sets of commissioning arrangements which had not been designed with that purpose in mind but which were, in practice, operating in areas of interdependence.
- d. Underdeveloped systems are poor foundations for integrated working but the process of seeking to bridge the two systems can help to strengthen the internal structures on which integrated approaches must rest.
- e. There is a continuing need to map and understand this interface in terms of its opportunities and challenges for improving health and wellbeing outcomes in local settings.
- f. Basic understandings of the two approaches, their areas of interdependence and how they might be more effectively

integrated are also continuing learning and development needs nationally, regionally and locally.

3. Shaping the Solutions

- a. Such learning could be promoted by the adoption of concepts and frameworks which have been explored and refined through the pilot programme.
- b. The **outcomes, focus, infrastructure** framework is a helpful way of structuring approaches to integration. It provides a framework for linking person centred commissioning with pathway and service re-design underpinned by appropriate knowledge, skills, resources and structures for the realisation of identified outcomes.
- c. The re-conceptualisation of care pathways as **'end to end' or 'home to home' pathway planning** provides a more holistic framework for engaging and bridging;
 - i. Prevention, care, treatment and reablement
 - ii. Acute services, primary care and public health
 - iii. Social care and other local authority responsibilities for inclusion and wellbeing
 - iv. The NHS, local government and independent sectors
- d. Joint commissioning between PBC and social care for person centred outcomes should operate at and between **different levels of whole systems working**
 - i. **Whole systems strategic (macro) commissioning**
 - ii. **Whole person individual (micro) commissioning**
- e. The nature and form of the latter depends on the how arrangements for personalisation and individual budgets are being implemented locally in the NHS and local government. At least four sets of inter-relationships are possible at the level of individuals receiving both NHS and social care resources
 - i. Social care 'IBs' integrated/aligned with 'mainstream' NHS forms of assessment and case management
 - ii. Social care 'IBs' integrated/aligned with 'GP flexibilities' to commission 'non health interventions' and create an actual or virtual joint resource allocation
 - iii. Social care 'IBs' integrated/aligned with NHS 'IBs' to create an actual or virtual joint resource allocation
 - iv. NHS 'IBs' integrated/aligned with traditional social care forms of assessment and case management
- f. Understanding and managing these different forms of interrelationship between NHS and local authority arrangements for personalised resource allocation is a significant priority for developmental, learning and research programmes.

- g. The implications of and interrelationships between social care 'IBs' and the NHS is an urgent and immediate priority as the former are rolled out across England as a whole.

4. Building the Foundations

The engagement of primary care in joint commissioning was beginning to create new possibilities at the interface with local government:

- a. Person centred commissioning was reinforced by GPs bringing their day to day contact with the public to the heart of the process. Conversely, personal practice was being influenced by involvement in commissioning
- b. Both primary and social care representatives learned more about what each could offer the other's service users. For example one of the GP leads had added social prescribing to his menu of options
- c. The experience of working alongside each other was leading them to recognise their mutual interest in commissioning care closer to home and in combining resources to provide more appropriate and holistic care.
- d. Champions of closer working between primary care and local government. were emerging and new alliances were being formed

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CSIP Eastern

Integrated PBC and Social Care Commissioning Evaluation

Round 1: Interview Schedule

1. Title of Project, aims and objectives
 - a. Focus: population and user group(s)
 - b. How described? (structure, service redesign, outcomes, efficiencies, responsiveness to local and individual needs)
 - c. Partners: statutory, 3rd sector, private, public and users/carers
 - d. Milestones established, current state of play
2. Context
 - a. Service structure, care models, perceived and/or evidenced strengths and weaknesses (views of users, carers, community; primary care and local authority commissioners, monitoring and regulation)
 - b. Organisational structures, commissioning (health and social care/LA(?), role of primary care, providers including sectors, services and influence over commissioning, LSP/LAA, perceived/evidenced strengths and weaknesses of health and social care commissioning, individually and collectively (including experience to share in context of PBC/plurality), DPs and IC)
 - c. Trajectory of service development and organisational relationships, how intend to change or reinforce those paths/trends?
 - d. Needs analysis, strategic and individual
3. Origins of project
 - a. How originate, when and who were prime initiators/movers
 - b. Principal drivers and/or goals
 - c. Local priorities?
4. Anticipated benefits
 - a. Service users
 - b. Carers
 - c. Community (place), social exclusion and sustainable community strategy, public involvement in commissioning service provision
 - d. Financial/better value/cost effectiveness
 - e. Organisational goals, commissioners, providers
 - f. How will you know you are achieving organisational and individual benefits?

5. Role and potential of PBC
 - a. What different dimension does PBC bring (to nature of relationship with providers, service models, nature of relationship with other commissioners)
 - b. What benefits do GPs perceive they will derive from PBC, how far are they signed up to it?
 - c. What does it allow you do differently?
 - d. What additional leverage and incentives does it make available and to whom, in principle and in practice here
 - e. How far is PBC the critical factor in change strategy, necessary and/or sufficient?
 - f. How far will it change what they want and are able to commission?
 - g. Integration/alignment with social care commissioning including development of personalised commissioning

6. Funding Strategies
 - a. Investment implications of commissioning strategy and for whom?
 - b. How align funding streams with commissioning objectives
 - c. Sustainability of re-aligned funding
 - d. Managing the transition, role of/for PbR
 - e. Adequacy

7. Major challenges to achieving project goals?
 - a. Consensus on goals
 - b. Capacity, capability and leadership
 - c. Governance and accountability
 - d. Provider development

8. Commissioning Guidance
 - a. Extent of awareness of NHS framework and health and wellbeing framework
 - b. Discussion of consultation document and responses
 - c. Assessment of its potential contribution to overcoming problems
 - d. Putting people at the centre
 - e. Provision of greater financial flexibility across health and social care

9. Monitoring, evaluation and development support
 - a. How are you planning to monitor and evaluate your project?
 - b. What criteria and measures will you use?
 - c. What assistance might be helpful from the CSIP project team?
Is there any other assistance which might be helpful to the development and implementation of project?

Appendix 2

CSIP Eastern Region PILOTING INTEGRATED APPROACHES TO PbC and SOCIAL CARE COMMISSIONING

Interview Schedule: Round 2

1. What is the target population for the pilot?
 - a. Size and geographical location
 - b. Needs: socioeconomic and care needs
 - c. Sources of information about need, how collected, including role of public engagement
2. What outcomes is the pilot seeking to achieve on behalf of/with the target population?
 - a. Where did outcomes come from?
 - b. Who involved in defining them and how agreed/endorsed?
3. In a sentence, what are the aims of the pilot?
4. What, if any, changes in the design of care pathways are required to achieve these aims and realise these outcomes?
 - a. What are the implications of these changes for the range, structure and quality of provision and providers?
 - b. Are these implications accepted and agreed by commissioners and providers?
 - c. If so, how was agreement secured and from was such agreement required?
 - d. Have you secured appropriate levels of (i) public engagement and (ii) professional engagement {or political and managerial)
5. What is the expected contribution of a more integrated approach to PBC and social care commissioning in terms of the pilot's ability to secure and deliver these changes in care pathways and provision?
 - a. What differences do PBC and more personalised social care commissioning bring to relationships between commissioners, between commissioners and providers, between all of them and patients/service users
 - b. What do they allow you do differently? How far will they change what can be commissioned by either or both services?
 - c. What additional leverage and incentives does it make available and to whom, in principle and in practice here

- d. How far are you pursuing closer integration of PBC/personalised social care commissioning because it provides greater flexibility in the use of resources?
 - e. Are there, in practice, sufficient flexibilities and are you able to take advantage of them?
6. What, if any, changes in organisational arrangements and infrastructures needed to enable the agreed outcomes to be commissioned through the changed care pathways and provision (e.g. commissioning arrangements, collaborative working, information gathering or sharing, evidence base for commissioning, knowledge management)?
7. What are the anticipated benefits of these changes for:
- a. Service users
 - b. Carers
 - c. Community (place), social exclusion and sustainable community strategy, public involvement in commissioning service provision
 - d. Financial/better value/cost effectiveness
 - e. Organisational goals, commissioners, providers
 - f. How will you know you are achieving organisational and individual benefits?
8. Extent of progress
- a. How far have you been able to achieve the pilot's aims to date and how far will you have been able to achieve them by the end of March 2008? (Cover service changes and infrastructure changes separately).
 - b. How much progress has been achieved in relation to different components of the commissioning cycle
 - c. What have been the principal challenges with which you have been faced and how far have you been able to meet them (including financial, prioritisation of investment, decommissioning)?
 - d. What have been the most effective levers and incentives you have been able to employ to secure change?
 - e. What, if any, gaps in capacity and capability has the pilot enabled you to identify (e.g. JSNA and 11 WCC competencies)?
 - f. What, if any, gaps in mechanisms to secure agreement and accountability has the pilot enabled you to identify?
 - g. How far are the gaps and challenges inherent in the nature of PBC and personalised social care commissioning and how far are they features of seeking to bring those processes more closely together?

- h. In practice, has a 12 month programme been realistic timescale given the management of change implications of your aims?
- i. Are there any features of the context in which you have been working during 2007/08 that have made progress particularly difficult?
- j. How much more might you be able to achieve by end of the 2008 calendar year?
- k. What additional resources, levers or support might enable you to maximise the extent of progress during 2008?
- l. How far might WCC help?

About the Integrated Care Network

The Integrated Care Network (ICN) provides information and support to frontline NHS and local government organisations seeking to improve the quality of provision to service users, patients and carers by integrating the planning and delivery of services. Key to the role of the ICN is facilitating communication between frontline organisations and government, so that policy and practice inform each other effectively. The ICN is part of the Care Services Improvement Partnership (CSIP) at the Department of Health.

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