Coherent health and care: Possible future scenarios

Briefing paper

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Executive summary

The future of health and care will be driven by three common forces:

- the need to make services personal for each individual, to deliver effective services that people understand, trust and control;
- the need to deliver more services for less money as demand grows, public services funding tightens and a new deal is struck between the state and citizens; and
- putting clinicians in charge of NHS priorities, services and funding through ‘Liberating the NHS’.

As these forces combine new approaches to integrating services around individuals making their own choices with their personal budgets will be required. The opportunity is there for local communities and service providers to change commissioning and funding so that individuals make real choices between integrated options. Coherence across health and care, within communities and across localities, will be achievable if local leaders take the chance to reshape relationships, funding and behaviours to support choice and integration.

This paper sets out the strengthened case for integration driven by personalised services in a more austere financial climate. It goes on the look at the opportunities to bring services together, and explores the choices confronting local leaders on culture, commissioning and service provision. A range of potential scenarios are set out to help leaders make the best choices for their communities and services.

Introduction

The health white paper stresses that better integrated health and social care services at all levels of the system are essential to improving outcomes for local people. Integration is to be achieved at: the strategic population level; operationally between different services; and at the level of the individual service user. Local governance is to be integrated via the new Health and Well Being Boards focusing on leading health improvement and commissioning for the local population as a whole. They will be led by local authorities, and include health services commissioners, principally GP Commissioning Consortia and other local partners. GP Commissioning Consortia aim to strengthen clinical leadership and shape integrated health services for individual patients. At the individual level personalisation is designed to empower people to select and integrate their own chosen services based on negotiated self directed support plans. Whilst each of these developments can support integration they can also be implemented in ways that do not.

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1 Equity and Excellence: Liberating the NHS, DH 2010
2 Equity and Excellence: Liberating the NHS, DH 2010. For a summary of the white paper’s implications for local authorities see ‘The Health White Paper: Opportunities for local government to improve health outcomes’, briefing paper, Catherine Staite, OPM, August 2010
Currently much of the focus of integration has been on changes that improve the connections between different professionals involved in care pathways. However to have a real impact on outcomes it also needs to empower service users to more effectively meet their own needs, ‘no decision about me, without me’. This will include: redesigning integrated care pathways so that they focus on integration around service users; and rethinking the staff skill mix to best complement and boost the capacities of service users and their social networks to meet their own needs. The effectiveness of this approach is evidenced in health care through the success of self managed care for long term health conditions, leading to less use of urgent and emergency hospital care, and in social care through personalisation delivering more choice and independence.

Personalisation, underpinned by the widest possible application of personal budgets in social care and ever wider access to personal health budgets will devolve much of the commissioning power to individuals. They will take the lead in integrating their resources and demanding new types of services and providers that work for them. At the same time the provider market is undergoing radical change. Local authorities are moving to outsource remaining social care provision and community health services, previously managed by PCTs, are now moving out into a variety of free standing and merged provider organisations. Provision of both health and social care is being opened up to a wider range of willing providers responding to the individual demands of patients and citizens. All these changes will increase the number of providers and make integrating services more complex.

Both devolved commissioning and an increasingly diverse provider market change the role of commissioners. They will have an even more important role in: keeping track of overall need; providing information; assisting change; reviewing effectiveness; and achieving the efficient use of tighter budgets. However they will be less able to rely on the leverage previously available through block contracting. Instead they will have to work much more through influence to shape the provider market. Hence the commissioning levers used to enable integration will also have to change.

The changes in commissioning and providing are happening at a time when there is a big squeeze on commissioning resources. Local authorities have to reduce spend by 28% over four years and will wish to protect front line services while doing this. GP consortia will have significantly reduced management budgets from which to fund their commissioning activities. Together these reductions in commissioning resources are leading to a search for more efficient approaches to commissioning which may lead to greater cross sector integration. However there are also powerful drivers for commissioners to simply focus on retaining or increasing their leverage within their separate health and social care markets.

This paper makes the case for greater health and social care integration and with other sectors. It identifies how service level integration, strategic commissioning and procurement and personalisation can be shaped to enable this to happen. Structural integration to support process integration is also possible. However other major drivers may work against it. Ways of squaring the circle to enable integration under different commissioner and provider reconfigurations are therefore explored.
What to integrate, why and for whom?

Integration covers a very broad spectrum of outcomes and activities. This paper does not attempt to encompass all aspects. Instead it focuses on integrations that impact on people who currently simultaneously receive a service from both health and social care.

Integration for whom?

The majority of people who receive simultaneous support from both health and social care are those that require help to best manage their long term health conditions or are in need of support from rapid reablement services. Figure 1 shows that these two groups of people can be characterised by those who require:

A. Health only rapid reablement – that enables a person to regain full functioning without the need for adaptations and social care support

B. Heath and social care rapid reablement only – that enables a person to regain some of their previous functioning and with adaptations and short term social care support to continue to live independently without further support.

C. People with long term conditions who are supported by health and social care, who also require rapid reablement – enabling a person whose current health condition requires continuing health and social care support and, for example, has a fall that requires hospitalisation to regain sufficient function to continue to be supported in their own home.

D. People with long term health conditions who require health support only – who can otherwise manage their lives without the need of further support.

E. People with long term health conditions who require continuing health and social care support – a large proportion of especially older people supported by social care fall into this group.

This paper focuses on the integration of services for the subset of people, represented by groups B, C and E, who use both health and social care services.
Why integrate?

Apart from the overarching policy drivers there are several reasons why integration makes sense:

- **Improved outcomes** – enabling independence and avoiding the need for residential and nursing home care through early intervention, reablement and getting the right combination of services to a person, at the right time.

- **People in control** – by integrating services around a person, individuals are enabled to take an active part in deciding how best they are supported and to contribute more effectively to their own continuing well being.

- **Seamless service** – reduces or eliminates the handovers between different services and groups of professionals and the need for individuals to continuously tell the same story to different professionals.

- **Efficient** – integrated processes, task sharing and enabling individuals to effectively self care reduce the amount of time to support any one person.

- **Cost saving** – through both more efficient support processes that enable self management of conditions and as a result of better outcomes that reduce the need for more costly interventions and intensive social care support

Whilst integration is mostly focused on enabling more efficient coordination between different professionals and services, its most important goal is achieving better outcomes. To do so it is important to recognise that services in themselves do not produce outcomes. It is what people do for themselves, effectively supported by services that coproduce outcomes. Hence integration will be at its most effective when it takes into account what people and their social networks do for themselves, and enhances the effectiveness of this action through the redesign of services. It is this integrated re engineering of services that will makes best use of both people’s
own resources and those of organisations to deliver the required improvements in outcomes, efficiency gains and cost savings.

How?

Many of the gains from integration can be achieved through changes in process and working culture for example:

- **People in the driving seat** – enabling people receiving services to be central to setting outcomes and how they can be best achieved and sustained.
- **Single Assessment Process** – used by all professionals
- **Single plan** – developed with the individual and worked to by all professionals
- **Single coordinator** – who enables the care plan to be agreed and ensures that the team around the person works to it.
- **Task sharing** – between staff to reduce the number of people with whom a person has to interact and enable easier communication between staff.

These new ways of working require support which can take a number of forms, for example:

- Integrated health and social care information systems – that enable rapid sharing of information between professionals and with the person being supported.
- A single point of contact for people who experience an unexpected change in their needs or whose services fail – operating on a 24/7 basis, linked to case management and out of hours services.
- Training and support programmes for staff – to help them move from being service providers to enabling people to self manage their conditions, develop or retain their self care capacity and build the social networks that everyone requires for support.
- Training and support programmes for service users – to enable them to develop sustainable self care skills, be able to use equipment and follow diagnostic procedures and take appropriate action to better self manage their health conditions.
- Multi disciplinary networks and teams – built around both care pathways and localities that enable the coordination of staff working with different individuals. This may or may not include the creation of joint provider organisations.

Integration will be most effective when it explicitly recognises and supports people to be effective coproducers of health and social care outcomes.

Personalisation and integration

The government's 'Vision for Social Care'³ and the sector wide agreement 'Think Local, Act Personal'⁴ require local authorities to continue to move forward on

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³ ‘A vision for adult social care: capable communities and active citizens’, DH November 2010
⁴ ‘Think local, act personal: next steps for transforming adult social care’, November 2010
personalisation and ensure that personal budgets are available to all. Building on the previous Putting People First policy personalisation will encompass:

- **Personal budgets** – in health, social care, employment and education to enable people to decide, within agreed budget limits, what support will best enable them to meet their assessed needs and enable them to purchase it directly from providers of their own choice. This has been shown to produce better outcomes for the same or less outlay compared with centrally commissioned services. Personal budgets are used to fund self directed support plans. These go further than identifying which services a budget holder will purchase to include what the person will do for themselves and what other services not funded by their personal budget they will also use. This overview of the total support package on which an individual will draw provides the foundation stone for integrating services around individuals in the new marketplace.

- **Pre funded - personalised focused services** – focused services that continue to be funded outside of personal budgets will also need to be personalised. This includes rapid reablement where there would be insufficient time to set up a personal budget. The aim is to ensure that all services: treat people as co-producers of outcomes; and are designed to build on and further develop the capacity of people and their social networks to regain or sustain their independence. These are the core requirements of a personalised approach to integration.

- **Personalised universal services** – where primary care, colleges, leisure centres and other universal services are tailored to the needs of all. This enables people with support needs to use them and become, or remain, part of the wider community. Integration works best when it enables people to maximise use of universal services.

- **Social capital** – friends and neighbours, community associations that welcome all and being welcomed rather than harassed when you are out and about are key components of social capital that are essential to health and well being. Hence integration should provide support in a way that enables people and local communities to build on their existing social capital.

**Implications for integration**

In the future, apart from situations where people will have only a short term contact with social care e.g. some of the people using rapid reablement, all people in receipt of state supported social care will purchase their services through the use of a personal budget. As personal budgets are rolled out in health significant parts of the community health provision or alternatives that yield the same or better health impacts will be directly purchased by budget holders. This as Table 1 shows, this does not necessarily mean that they will be supplied by providers in the health sector.

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### Table 1: Current and forecast services that people will buy using personal health budgets

<table>
<thead>
<tr>
<th>Health services</th>
<th>Broader health and well being</th>
<th>Information, brokerage and access</th>
<th>Social care</th>
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<tr>
<td>crisis intervention, nursing and hospice care, pain control</td>
<td>alternative services i.e. swimming lessons, gym membership, exercise classes, massage and alternative therapies</td>
<td>information services care planning support to access community/mainstream services (largely for those with learning difficulties or mental health needs) training for professionals transport</td>
<td>one to one and befriending services support workers/care assistants/personal assistants flexible homecare respite breaks, including holidays driving lessons, shopping trips lifestyle support, including for carers</td>
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<td>maternity services i.e. midwives, pre and post natal support, post natal depression, breastfeeding</td>
<td>sensory units and equipment, IT, ad hoc purchases/one-off’s</td>
<td></td>
<td></td>
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<tr>
<td>chiropody, orthotics, physiotherapy and occupational therapy</td>
<td>cookery or nutrition courses, education, weight management</td>
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<tr>
<td>tele-health CBT, counselling well being/health checks, including for carers</td>
<td>incidentals and one-off goods i.e. televisions, computers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>expert patient programmes, medication management, smoking cessation</td>
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Depending on how they are developed, personalisation and integration can become conflictual or be mutually supportive approaches. Conflict will occur if integration focuses on just linking services and professionals or focuses on individuals but in a way that service providers retain control of decision making. Tensions will also arise where personalisation is solely focused on individual purchasing and neglects the need to focus on coproduction and remodel services accordingly. The real synergies between personalisation and integration will be realised when they both focus on enabling the most effective coproduction of outcomes by putting service users in the driving seat. This can be achieved by focusing integration on individuals and re-engineering both services and professional practice to support a single personalised support plan negotiated with the service user. The same principles of enabling effective coproduction through the use of a single, service user negotiated support

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6 Contracting and market development to support the use of personal health budgets, Discussion paper, Miller C, Department of Health, June 2010
plan hold for situations such as rapid reablement where the use of personal budgets may not be appropriate.

**Finance**

The dominance of acute services concerns in the health sector can lead to a perception that primary and community health care comprise only a small part of total health spend. In fact a significant proportion of the total NHS budget is spent on community health services and primary health care. There is also continuing pressure to further reduce the proportion of the total NHS budget spent on acute care through more effective primary prevention and the use of community and primary health care. Much of this is to be achieved through prevention and enabling effective self management of long term health conditions. Hence the primary focus for integration is on effectively linking community and primary health care and social care.

Figure 2 shows that how the prevalence of long term conditions (LTCs) rises from below 15% of the population cohort aged below 29 years and increases to over 50% for the cohort aged 56 years and above. 70% of people aged over 85 have LTCs.

At the same time the proportion of these two cohorts that have 2 or more LTCs increases from below 5% to around 20% from age 60 years to over 30% for people aged 80 years and more. As the population ages further both the proportion of the population as a whole with LTCs and those with 2 or more LTCs will increase still further.

**Figure 2: Ageing and the growth in long term conditions**

![Proportion of people with Long Term Conditions by age](chart)

The cost implications of LTCs for both health and social care can be gauged from the data displayed in Box 1. It shows that in the acute sector people with LTCs account for the vast majority of outpatient, accident and emergency attendances and inpatient bed days. In primary and community health LTCs account for over half of GP appointments and nearly 70% of health and social care spend. The total cross sector spend on people with LTCs is over £70bn per year. Hence there is an overwhelming economic argument for developing more effective, personalised, integrated approaches to LTCs.

**Box 1: The health and social care costs of long-term conditions**

- Total spend across health and social care on common users is over £70bn
  - nearly £40bn on older people
  - £20bn on mental health
  - nearly £10bn on learning difficulties plus the spend on physical disabilities (not collected separately by NHS)
- LTCs represent:
  - nearly 70% of health & social care spend
  - 55% of GP appointments
  - nearly 70% of outpatient and accident and emergency attendances
  - nearly 80% of in patient bed days

For integration to be effective it must be tailored to the needs of different groups of people. Our previous analysis (Figure 1) identified three groups of people who need integrated health and social care:

- **B. People requiring health and social care rapid reablement only** – that enables a person to regain some of their previous functioning and with adaptations and short term social care support to continue to live independently.

- **C. People with long term conditions who are supported by health and social care, who also require rapid reablement** – enabling a person whose current health condition requires continuing health and social care support and, for example, has a fall that requires hospitalisation to regain sufficient function to continue to be supported in their own home.

- **E. People with long term health conditions who require continuing health and social care support** – a large proportion of especially older people supported by social care fall into this group.

Group E, per person, absorbs most of the joint spend on health and social care. Effective personalisation and integration of services can improve outcomes and slow down the loss of independence. Both of these will also result in cost savings. Unless there is effective reablement a good proportion of people in Group B could continue to suffer from conditions which will become long term, swelling the numbers in Group E. Equally effective reablement for Group C can promote independence and reduce the need for higher levels of support. Hence both health improvement and cost savings require a coordinated approach to meeting the needs of these three groups of service users.
Financial control

The shift to personal budgets will change the way in which finances are managed in both health and social care. Personal budgets will be funded from spend that was previously channelled to providers through block and select list spot purchased contracts. The widespread use of personal budgets will require a winding down of all of these contracts and their replacement by individual contracts between budget holders and providers. This has implications for both providers and commissioners.

Providers

Providers will experience:

- **Reductions in, or elimination of, block contracts** – whilst community health providers will continue to provide services to people who only require health care or rapid reablement via block contracts the rest of their services will move into a retail market. Apart from social care providers who provide rapid reablement all social care provision will be provided on a retail basis.

- **Direct relationship with service users** – whilst some social care and a minority of health services are already provided on a retail basis for the majority of providers working directly to service users will be a completely new experience. It will require changes in both costing and billing systems and in the way services are marketed.

- **Management** – staff management and leadership will need to be more local, flexible and empowering and relationships with regulators will need to take account of different models of staff leadership and accountability.

- **Risk spreading** – the loss of predictable funding previously provided by block contracts, the continuing downward pressure on prices from personal budget holders shopping around for best buy services and the entry of new providers into the market will increase the financial risk to providers. This is likely to lead to changes in business models as well as movement into new markets both in terms of service mix and geographical coverage. It may also lead to the development of collaborative alliances between providers of complementary services. Investment models for funders will also have to reflect this new risk picture.

Commissioners

Commissioners will have key roles to play in shaping and enabling the new retail market:

- **Information and advice** – ensuring that this is universally available to both personal budget holders and those who self fund their care. Providing web based and other means to enable easy contact between people and providers. GPs will remain key advisors and these systems will need to have specific access routes for GPs.

- **Negotiating and reviewing personal budgets** – ensuring that: funds are allocated and spent in line with assessed need; safeguarding is appropriately handled; people are enabled to exercise real choice and also have the option to directly manage their budget or delegate that to another party;
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- **Market shaping** – providing: aggregate analysis of how budget holders are spending their funds and what alternative services they would prefer to buy; forecasts of future demand; support to providers to personalise their services; and access to affordable finance e.g. through social impact bonds.

- **Framework contracting** – using zero volume contracts that require providers to supply personalised services and budget management support (individual service funds) and meet specified quality standards. These providers would then be recommended to budget holders who will still have the option of purchasing off framework.

- **Personalising services outside of personal budgets** – ensuring that continuing contracting arrangements for targeted services funded outside of personal budgets are centred on the delivery of personalised services. Working with universal service providers to remodel their services so that they meet the needs of all disabled and older people.

- **Enabling the development of community capacity** – by working with service providers to ensure this is built into the way they personalise their services. Enabling the development of Big Society initiatives that help isolated people connect into social networks and become active parts of their local communities.

**Funding the commissioning process**

The likelihood is that the majority of the social care budget and a significant proportion of the health budget will be controlled through the use of personal budgets. This will mean that the majority of the functions of social care commissioners and a significant proportion of those of health commissioners will shift from procuring and managing block contracts to providing appropriate market infrastructure and enabling the development of an effective retail market. The experience of the personal health budget pilots is that much of the health spend will be on services that promote healthy outcomes rather than on health services (see Table1, above). These are also services that promote social well being and independence. Hence both health and social care commissioners will be working in overlapping provider markets. The supporting processes required by budget holders to plan and manage their budgets are also common. Health commissioners involved in the personal health budget pilots are therefore discussing with their social care counterparts the potential for integrated commissioning at both the individual budget holder and market shaping levels. This might include:

- **Individual budget holder level** – a single health and social care self directed support plans for each budget holder; a single care manager who will negotiate and review the integrated plan with an individual; and pooling of funds within personal budgets.

- **Market level** – shared approaches and infrastructure for: information and advice provision; market shaping; and framework contracting.

The move towards this form of joint commissioning has been given further impetus by cuts in LA social care budgets and therefore the resources available to fund the commissioning process and the substantially reduced budgets for commissioning costs that will be available to GP consortia. In both cases shared infrastructure and processes look attractive options.
Structural implications

At the same time as the pressure to personalise and integrate is increasing, the NHS is undergoing major structural change. Local authorities faced with greatly reduced budgets are also reconsidering their structural arrangements. The choices made in both sectors could help or hinder further development of personalisation and integration.

Liberating the NHS

The white paper “Liberating the NHS” transfers the commissioning of the majority of acute, mental health and community health services from PCTs to GP Commissioning consortia. Community health services will move out of PCTs into freestanding provider organisations.

GP commissioning consortia

For GP Commissioning consortia, size matters, with many pressures to form large consortia or clusters of smaller consortia. Funds available to consortia to resource the commissioning process will be substantially less than those currently available to PCTs; hence pooling commissioning costs across a wider area than is currently covered by a PCT is attractive. As long as the whole of a local authority area and population (both registered and unregistered) are covered, GP consortia are free to set their own geographical boundaries. As a rule of thumb, to attract enough budget and encompass a large enough population to make the commissioning of a full range of health services viable, self-sufficient GP consortia or clusters of consortia are likely to be based on populations of 200,000 plus. A further incentive to increase size is the ability of a GP consortium to cover a sufficiently large part of a health economy to have the necessary clout to negotiate effectively with big acute sector providers.

There are also drivers to focus consortia on smaller areas notably that of a local authority or localities with an authority’s area. These include: the gains from being coterminous with commissioners of complementary services; a wish by some GPs to develop locally rooted and controlled services; the potential to merge some of all of a consortium’s commissioning capacity with that of the local authority; the transfer of the public health lead role to local authorities; and the requirement for GP consortia and local authorities to provide an integrated response to health and social care needs.

GP commissioning consortia have considerable freedom to decide how they will source their commissioning activity. They are free to carry out all of their commissioning themselves or to partly or wholly outsource their commissioning activities to other organisations. Hence some consortia will choose to retain all of their commissioning support activities in-house others will partly or fully outsource some of their activities. This could be to other consortia, for example through lead commissioning arrangements, or to local authorities or the private sector.
Implications for integration

There are various options for strengthening integration through GP Commissioning Consortia – some of these are structural, while others can be achieved through joint commissioning processes such as:

- Coterminousity with local authorities - consortia could adopt the same boundaries as a local authority or decide to encompass a larger area to commission acute and specialist services but work through sub consortia that are coterminous with LAs to commission other services.

- Merged commissioning processes with local authorities - a local authority could: host all or part of a consortium’s or a coterminous sub consortium’s commissioning in a single joint commissioning unit; or agree joint commissioning processes and pooled funding arrangements to be used with the consortium(s) covering its area.

- Pan local authority commissioning - whilst it is possible that there may be alignment of some commissioning activities with local authority areas it is also likely that some consortia will wish to handle the commissioning of integrated health and social care services on a larger scale. For example, they may argue that the infrastructure costs of supporting the effective use of personal budgets are high and could be most efficiently managed by spreading them across a number of local authority areas. This shared infrastructure would reduce the costs to providers of operating in the joint market and hence increase the number of providers to make their services available across the set of authorities. Hence neighbouring local authorities would be challenged to collaborate with one another as well as with the GP consortium that covers their areas around, for example, common framework contracts, web based information systems and provider development.

Community health providers

Prior to, but confirmed by, the new health white paper PCTs were enabling their community health service providers to become free standing organisations. This must now be achieved by April 2011. At the same time the introduction of ‘Any Willing Provider’ (AWP) in health, the potential impact of personal health budgets and the likelihood that some GPs will bid to become community health providers will increase competition in the provider market. This will challenge the financial viability of community health providers that wish to set up as freestanding organisations within their existing PCT area. There are therefore considerable pressures to consider mergers either with other health service providers or with social care providers. This is indeed part of the evolving picture. Examples of the new arrangements are: retention of existing community health service providers, merged community health and acute health service and mental health services providers; merged community health and social care providers; and new providers.

Implications for integration

The roll out personal health budgets will reduce the block contracted funding to community health providers. There will be a continuing need for clinical expertise. However it is the way that this is made available to people and focused on their
needs that will have to change. For example, great progress has been made in creating integrated care pathways however these have mostly focused on the integration of the work of different clinicians and other professionals. The provision of personalised services will require that integration also focuses on improving: the quality of the experience of the person being provided with the service; how the process enhances their capacity of self care; and the control they have over who provides, what to them, when and where. These changes are as applicable to rapid reablement as they are to people with long term conditions. Hence the challenge to both health and social care commissioners will be to enable this change in culture and process within a more flexible and diverse service delivery market.

The changes in working practices and culture required to deliver personalised integrated services provides an opportunity for new or existing civil society and private sector providers to enter the market. Their ability to develop cost effective business models and recruit fresh teams of staff to work in completely new ways whilst still ensuring appropriate clinical governance will be attractive to some GP consortia. Hence there will be a further pressure for NHS community health providers to remodel their current services and potentially consider much closer integration with civil society and private sector providers.

**Local authority social care commissioning arrangements**

The government published its vision for the future of adult social care in November 2010 and will incorporate the vision and the outcomes of the commissions on adult social care law and the funding of long term care into a white paper in 2011. The vision reinforced the health white paper’s stress on the need for better health and social care integration at all levels. The proposed new Health and Well Being Boards in each LA area will have the remit to ensure effective integration and representatives of relevant GP consortia will be members of their local board. Joint commissioning and delivery of some services notably mental health and learning disabilities is well advanced in many LAs and enshrined in Partnership Trusts. Other services are noticeably less well integrated.

The impact of personal budgets in adult social care will lead to greater diversity in the provider market and will require a new relationship between commissioners, providers and budget holders. This trend may be further accelerated in some LA areas by the growth in people self funding their social care, especially amongst older people. Independent of any pressure from GP consortia to do so, both to reduce commissioning costs and to make it cheaper and easier for new, innovative providers to enter their local markets neighbouring Local Authorities may develop a common market shaping infrastructure\(^7\). This might include framework contracts, billing systems and web based supports such as shop4support. This could also be used to support the use of personal budgets in housing and employment support as well as in health.

\(^7\) ‘Commissioning for personalised outcomes’, Bennett.S and Miller.C, Department of Health, 2009
Implications for integration

In the future the only social care services that are likely to be block contracted are those that people who require no continuing support use for short periods of time e.g. rapid reablement. The extension of personalisation to all people with learning disabilities and those who suffer mental ill health will mean that service integration through the block commissioning of Partnership Trusts will end. It will then be up to these organisations to decide whether or not they can provide personalised services that budget holders require and compete with other providers to do so.

The cuts in budgets for children’s services which are mostly commissioned by schools may lead to smaller or outsourced local authority provision and a much smaller commissioning function. This is currently leading a number of local authorities to merge the organisation of both their adults and children’s services into single People Directorates. This will also enable more effective support to be provided for the use of individual budgets for disabled children (see the SEN and Disability Green Paper\(^8\)) and those with complex health needs and facilitate the integration of adult and children’s services around families faced with multiple challenges.

The development of community or ‘place’ based budgets that allow the pooling of resources both within local authorities and with partners to tackle social issues that require an integrated approach will further fuel innovation. This also holds the possibility of: local agreements to pool budgets around certain groups of people with common, complex needs; the development of more innovative ways of meeting them; raising funds via social impact bonds on a payment by results basis; and sharing the cost savings that result. This would not only enable better outcomes for people but also move the commissioning debate away from concerns about cost shunting to the incentives of shared savings.

Some possible integration scenarios

There will be no one way in which the new commissioning and provider arrangements in health and social care will develop. Hence integration will have to take many different forms depending on the local environment. Each sector will have to decide the degree (see Figure 3) to which it wishes to integrate to realise the potential economies and leverage that can come from greater scale and the opportunities of presented by widening the scope of services being commissioned and provided via cross sector integration. Given the differing pressures on sectors and the variety of local circumstances it is unlikely that this will lead to a uniform pattern of choices across the country.

\(^8\) ‘Support and aspiration: A new approach to special educational needs and disability – a consultation’, DfES, March 2011
Currently most PCTs and LAs have a local, though not necessarily coterminous, focus and are structurally separate. However, this does not preclude the development of joint commissioning processes and integrated provision. A few PCTs and LAs have merged their structures to focus on commissioning cross-sector services across a local area. Both of these options could continue with single GP consortia, or clusters of consortia, substituted for PCTs.

Driven by reduced funding for commissioning activities and the wish to get wider market leverage, it is also possible that either or both GP consortia and neighbouring LAs will join forces to commission services across wider geographical areas. This may take place separately within health and adult social care or joint cross-sector alliances or organisations may be formed. Where sectors operate for wider area integration, there will still be scope to develop joint commissioning processes across sectors. The three scenarios below explore how integration can be achieved regardless of the choices being made in the different sectors.
A. Totally local

The small size of the LA and the close working links previously developed between health and social care have led to the formation of a single GP consortium that is coterminous with the borough. Building on previous locality based links with adult social care and children’s services the consortium is organised around three locality based sub consortia. The agreement to make the localities coterminous with current schools clusters was key to securing buy in from the schools’ forum to integrate the support for both adult and children’s services commissioning. Previous discussions about merging the PCT and the local authority have also led to an agreement by the local authority to host the GP consortium’s commissioning staff many of whom are shared with the local authority. This both reduces costs and enables further integration especially around shaping and supporting the development of a personalised services market. The GP consortium has lead commissioning arrangements with its neighbouring consortia through which acute services are commissioned.

The movement of the local authority’s social care provision into an arms length trading unit has provided the basis for a merger with the current community health service provider. The GP consortium is committed to rolling out and, when possible, pooling personal health and social care budgets. This coupled with the proliferation of choice in the personalised services market will present future challenges to the merged provider.

B. Alliances for integration

Building on previous connections between GP practices involved in practice based commissioning, and supported by a single private sector commissioning support provider, three GP consortia spanning two neighbouring LAs are collaborating to jointly commission health services. The private sector commissioning support staff work closely with the two LAs around joint commissioning issues, public health and safeguarding.

The community health service provider has merged with two others and now covers three local authority areas. However it has maintained a structure that enables it to focus separately on each of the three local authority areas. This increase in size is designed to both enable it to innovate and to withstand the impact of competitive pressures from alternative providers. Both LAs plan to move their remaining adult social care provider services into a jointly owned arms length business unit to enable them to compete on a level playing field with other providers as personal budgets are rolled out. The LAs are also pooling their resources to jointly commission common market shaping infrastructure including framework contracts and a shared web based system to enable budget holders and self funders to search for, and exchange views on services and providers. In one of the LAs the commissioning of adults’ and children’s service is being integrated.
C. Whole health economy

Four GP consortia have formed. Two are coterminous with one of each of two neighbouring LAs and the other two cover half each of a third much larger neighbouring LA.

There are two acute sector providers in the local health economy. The community health provider in one of the LAs has merged with one of the acute sector providers whilst the other three community health service providers in the other two local authorities have merged with the other acute service provider. In both cases the aim of the mergers is to integrate health care and maintain a viable community health service in the face of likely growing competition from alternative providers and the impact of personal health budgets.

In response to the acute and community health mergers the four GP consortia have come together to pool their commissioning support staff in order to be able to exert maximum leverage over these new providers.

The three LAs have integrated their adult social care commissioning functions and negotiated lead commissioner roles for older people’s, learning difficulties and mental health services with the four GP consortia. This not only promotes integration but is also welcomed by the GP consortia as a means of managing market reshaping as personal health budgets are rolled out. The integration is also designed to enable closer working between the LAs’ joint combined commissioning unit and the GP consortia’s pooled commissioning support staff. In neither of the three neighbouring authorities is the commissioning of adults’ and children’s services being integrated.

These scenarios are not put forward as recommendations rather they are descriptions of some of ways in which mixes of integrated structures and commissioning processes and provider reconfigurations are evolving. The usefulness of the scenarios lies in their capturing the interactions between a number of changes that are often been decided in isolation from one another. Unless local decision makers make these connections it is likely that opportunities to promote integrated, person driven services will be overlooked.

Transforming commissioning and provision

This paper has focused on the main changes that will be required to realise the potential of coproduction through integrations that empower people to achieve better health outcomes and maximise their own independence. Probably the most important change required is to a practice culture that recognises and further develops the capacity of service users and their social networks as coproducers of outcomes. This culture change will have to be enabled within a far more diverse provider market requiring very different approaches to commissioning. The key changes in culture, commissioning and service providers that will be required are summarised in Table 3.
<table>
<thead>
<tr>
<th>Aspect of practice</th>
<th>Current practice</th>
<th>Future practice</th>
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<tbody>
<tr>
<td><strong>Culture</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>People are customers who expect a professional and tailored service</td>
<td>People are explicitly recognised as coproducers of outcomes</td>
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<tr>
<td></td>
<td>People will be consulted about their services, kept informed but professionals will make most of the decisions</td>
<td>People are co designers of the support they individually receive</td>
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<td></td>
<td>Except for self funders, resources will be controlled by professionals</td>
<td>Personal budgets are used to enable people to directly control the use of some or all of funds used for their support.</td>
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<td></td>
<td>Direct health and social care needs are the major focus of service delivery. Little planned use of universal services and links with community associations.</td>
<td>Wider needs that impact on health and social care needs are a key focus with explicit use being made of universal services and community associations.</td>
</tr>
<tr>
<td></td>
<td>Whilst there is some focus on enabling self care most is on caring for and treating people.</td>
<td>Boosting self care and management knowledge and skills and increasing people’s informal social support is central to all services.</td>
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<tr>
<td><strong>Commissioning</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Individual level commissioning</strong></td>
<td>People along with care coordinators of block purchased services together decide how best to coordinate their services.</td>
<td>Social care services and some health and other services funding is controlled via personal budgets. Where block</td>
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<td></td>
<td>Care managers and care coordinators integrate services around each individual.</td>
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<td></td>
<td>Single assessments and care plans exist but are: often superseded by other more specialist assessments and plans; difficult for people to understand; and have little force in enabling service integration.</td>
<td>Single self directed support plans are used as the common basis for all service integration and are in a form that is understandable to all.</td>
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<td></td>
<td>The services available are mostly predetermined through block contacts and</td>
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Table 3: A checklist for change
<table>
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<tr>
<th>Coherent health and care: Possible future scenarios</th>
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</thead>
<tbody>
<tr>
<td>spot purchase arrangements. contracted services are also used, care coordinators have flexibility to vary the service.</td>
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<tr>
<td><strong>Strategic level commissioning</strong></td>
</tr>
<tr>
<td>JSNAs are a statutory requirement but have limited power as integrated commissioning documents. Commissioning focuses mostly on the integration of targeted health and social are services. The majority of social care services and a significant proportion of health services are purchased through the use of personal budgets. Block contracts require the delivery of personalised services. Widespread collaboration between neighbouring LA social services commissioners and those in health to provide common infrastructure to support the retail service market.</td>
</tr>
<tr>
<td>Most contracting occurs via block contracts or pre arrange spot contracts. Most contracting occurs via block contracts or pre arrange spot contracts. Some but not widespread collaboration between commissioners in neighbouring local authorities. Some but not widespread collaboration between commissioners in neighbouring local authorities.</td>
</tr>
<tr>
<td><strong>Service provision</strong></td>
</tr>
<tr>
<td>The majority of health services that are critical to integration are provided by NHS service providers. Most social care services are provided by civil society and private sector organisations. Some LAs retain a significant proportion of in-</td>
</tr>
</tbody>
</table>
Few examples of integrated providers of health and social care

Growth in integrated civil society and private sector providers often focused around specific care pathways.

As the national timeline for transformation, see below, shows there are a sequence of opportunities to influence the practice cultures, commissioning and provision. The 'checklist for change' and the scenarios described in this paper provide tools for shaping the outcomes of this process.

**National timeline**

- **April 2011 – October 2011**: local shadow working arrangements are established and learning starts to be shared through network.
- **October 2011 – April 2012**: disseminating learning and widening network to all areas
- **April 2012 – April 2013**: health and wellbeing boards operating in all areas on non-statutory basis, co-producing joint health and well-being strategies as basis for GP consortia and council commissioning.
- **April 2013 onwards**: GP Commissioning Consortia take on statutory role and lead most health commissioning, health and wellbeing boards in place in every area as vehicle for councils’ new leadership role in integrating commissioning.

**Conclusion**

At times of major organisational change there is a natural tendency for both organisations and whole sectors to become inward facing. This can lead to both a loss of focus on ultimate outcomes and the organisational processes and structures required to support them. This paper is avowedly outward facing. It embraces the renewed policy focus on service user empowerment and the role of social capital in delivering improved coproduced outcomes. It explores the practical implications for the reconfiguration of commissioning and service provision processes and structures. In sum it does the ground work that enables partners and local people to set the new outward facing local agenda for change.