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Ten years of jointly commissioning health and social care in England

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Abstract

Introduction: Over the past two decades, the service delivery landscape across health and social care in England has been reshaped in order to separate the *commissioning* of services from their *delivery*.

Policy/practice: The market ethic that underpinned this move has depicted the previously roles as unresponsive to the needs of service users and dominated by provider interests. As well as seeming to offer commissioners the chance to change the nature of provision and type of provider, this policy model also created a further new opportunity—for *joint commissioning* across organisational boundaries. The logic here is that if two or more commissioners can jointly shape their programmes then they will be better able to secure integrated provision across a range of separate agencies and professions.

Conclusion: This article reviews the experience of joint commissioning across health and social care over the past decade in England. It contrasts the proliferation of policies against the paucity of achievements, seeks explanations for this situation, and offers pointers for future development.

Keywords

joint commissioning, health and social care, policy developments, top-down implementation, front-line professionals, network development

1. Policy imperatives and policy proliferation

The general policy popularity of 'partnership' cannot be doubted—Glasby and Dickinson note that the term was recorded 11,319 times in 2006 in official parliamentary records, compared with only 38 times in 1989 [1]. This is reflected in national polices on health (the remit of the National Health Service) and social care (the remit of local government) which have frequently emphasised joint working as a way to achieve improved outcomes for service users. Examples include major pronouncements on local government [2], social care [3] and personalisation [4].

The more specific issue of joint commissioning can be understood as the process of ensuring that health and care services work effectively together to meet the needs of the population—a complex process with responsibilities ranging from assessing population needs, prioritising outcomes, procuring products and services, and managing service providers. Currently, the health commissioning role is undertaken by Primary Care Trusts (PCTs) and social care by local authorities (LAs).

There are many reasons for the growing interest in jointly commissioning health and social care, and these are summarised in Box 1.

There has been no shortage of policies in England seeking to bring health and social care closer together. Some of these stretch back long before the last decade to the 1970s, but the more specific interest in joint commissioning can be traced to the 1990s when the then Conservative government issued guidance on the subject which said that the Department of Health was committed "*to helping authorities achieve the potential benefits for service users and their carers that effective joint commissioning can bring*" [5; p. 9].

The incoming Labour Government of 1997 soon made its own enthusiasm for such arrangements equally clear, most notably with the Health Act 1999 [6] which not only created a duty of partnership but also significantly extended the ability of local authorities and the NHS to pool budgets for specific groups of services, delegate commissioning to a local organisation and create single provider organisations. This legislation (although now placed under the NHS Act 2006 [7]) remains in place, with pooled budgets constituting the most commonly used arrangement. Other possible arrangements for promoting joint commissioning include creating a Care Trust (combining NHS and LA health-related responsibilities within an NHS body under a single management) and making joint appointments across PCTs and LAs at all levels, including chief executive level.

Commissioning across the health and social care boundary was also specifically addressed by the Department of Health in 2007 with the publication of a 'commissioning framework' [8]. An important new proposal was the requirement upon local agencies to undertake joint strategic needs assessment (JSNA) designed to ensure that health, social services, and other local government stakeholders work together to define the needs of a local area. It was said that the framework was designed to enable commissioners to achieve:

- a shift towards services that are personal and maintain independence and dignity;
- a strategic orientation towards promoting health and wellbeing;
- a stronger focus on commissioning.

In May 2010, a new Coalition Government came into office and very soon issued changes to the 'operating framework' of the NHS. Although promising 'substantive systemic changes' for 2011/12, there is one note of ostensible stability:

"*The arrangements for joint planning between the NHS and social care must remain…Joint working and commissioning between PCTs and LAs will be of increased importance in order to deliver better outcomes for patients, service users and their carers.*" [9; p. 6].

There is, then, a clear policy thread running through the last decade which profiles and promotes joint commissioning across the health–social interface. But what has actually been achieved?

2. Policy implementation: what has been achieved?

There are undoubtedly some pockets of good practice, as seen in the examples outlined in Box 2 [10, 11], but

Box 1. Joint commissioning policy imperatives

Efficiency/Value for Money	Both the NHS and local government are facing huge budgetary reductions. Encouraging them to work together to achieve efficiency through joint commissioning may be one way of coping with this situation.
The 'Place' Agenda	An emerging policy focus in England is to look at the needs of geographical localities as a whole, rather than working in separate organisations. Joint commissioning could encourage PCTs and LAs to focus on working together rather than delivering silo-driven, centrally imposed targets.
Personalisation	Personalised support is a key policy objective in England. Individuals' needs rarely fit around traditional service boundaries, especially in the more complex cases. If services are to become more tailored to individual needs, a more coherent approach to support will be required.
Prevention	Prevention is seen as important as a means of driving efficiency and as a policy end in its own right which will improve people's quality of life. To be successful it will require numerous inputs of services and support that include (but also go beyond) both the NHS and social care.
Care Closer to Home	The opportunity for improvement created by joint commissioning is to enable more care to be provided closer to home and to reduce the use of expensive and often inappropriate residential and hospital services—key objectives for both PCTs and councils.
Overlap of Clientele	The people who make use of health and social care are often one and the same. In order to ensure a holistic view of their needs it is essential that their support is jointly planned and commissioned.

there is little evidence to suggest that achievements have been widespread. Although all local areas now produce a JSNA there is currently no evidence to show that that these have resulted in effective joint commissioning. Meanwhile, in a recent review of the use of the Health Act 1999, the Audit Commission [10] discovered that although the amounts placed in pooled budgets had indeed increased over the last decade, they still accounted for only around 3.4% of total health and social care expenditure. The bulk of this money has been used for relatively straightforward issues characterised by a consensus over means and ends, such as some learning disability services and integrated equipment services. Box 3 outlines one such service in Herefordshire.

By contrast, programmes for older people (the biggest users of services) have remained virtually untouched. All told, the Commission could discover little evidence to suggest that where pooled budgets *had* been used that they had led to improvements in people's lives.

These findings might be seen as a specific illustration of the general tendency towards pessimism in research findings on the achievements of partnering. Ramsay and Fulop's [12] summary of published research, for example, shows that it has mostly focused on process measures rather than outcome measures, and that methodologies for economic evaluation have been weak. Indeed, in a pessimistic review of the experience of partnership working in the UK public sector in 2005, the Audit Commission concluded that:

"*Local public bodies should be much more constructively critical about this form of working: it may not be the best solution in every case. They need to be clear about what they are trying to achieve and how they will achieve it by working in partnership*". [13; p. 2].

This is all compounded by the problem of attribution. The aims of partnerships are often similar to those of other public sector policies (such as improved efficiency and effectiveness) so demonstrating what it is *specifically* that partnerships aim to achieve outside of traditional models of service delivery is difficult. Wistow et al. [14] also point to the way in which the evidence bar tends to be set unrealistically high for investment in new developments compared with the case for maintaining spending on existing service patterns—an 'empirical tax' on innovation.

How can this relatively limited achievement be explained? There are four candidates: policy ambiguity and conflict; organisational turbulence; performance management frameworks; and power imbalances.

2.1. Policy ambiguity and conflict

The policy landscape in England is complex, confusing and, at times, contradictory. A major complication is the absence of a coherent national policy 'narrative', especially on the relationship between the twin imperatives of collaboration and competition. Government policy has promoted the greater use of choice and competition as a means for improving the performance of services while at the same time encouraging integration and cooperation. Adult social care in England has long been characterised by a market of competing providers from the independent sector. In the case of the NHS, market-based reforms such as the creation of Foundation Trusts and the introduction into hospitals of payment by results, has increased fragmentation and rivalry across the system. Although local government has had fewer

Box 2. Illustrations of Joint Commissioning

Bath and North East Somerset	Herefordshire	Knowsley
The PCT and council, working in equal partnership, have signed a Joint Working Agreement whereby child and adult health and social care and housing services are integrated using pooled funds combined with a two-way delegation of functions. Partners report to a partnership board that has overall responsibility for implementing and monitoring arrangements.	The PCT and Council explored the option of jointly planning, purchasing, designing and integrating all their local public services, but were unable to do so under current legislation. They are currently pursuing the integration of all public services covering strategic health and well-being as Herefordshire Public Services Partnership. There are joint appointments at all management levels with teams that work towards shared objectives and their joint Steering Group reports formally to the Council Cabinet and PCT Board.	The PCT and Council have widened their health and social care focus by consciously avoiding the care trust model and using the Health Act flexibilities to support a partnership throughout both organisations. This includes the key leadership role of Chief Executive NHS Knowsley—Executive Director of Council's Well-being Services (including Social Care and Leisure Services)—to create a health and well-being partnership board in line with its LAA. This has enabled it to jointly plan, commission and deliver services across the locality and use resources more flexibly, for example, reducing duplication in commissioning and procurement.

Source: Adapted from Audit Commission [10] and Hudson [11].

Box 3. Herefordshire Joint Equipment Pooled Fund

Herefordshire Council and Herefordshire PCT are coterminous public bodies serving a population of 178,000, of which older people account for one-fifth. They are separate legal entities, but have a history of partnership working, a number of jointly-appointed senior management posts and are working towards a more formal integrated structure. In 2004, they set up an integrated community equipment store, using a pooled fund, lead commissioning arrangements and a joint manager with joint accountability. The arrangement covers adult, children, health and social care budgets. Total expenditure is £564,000 (2007/08), contributions are 50:50 from April 2009 and risk and responsibility for out-turn is shared. The arrangement enables a central and immediate access point to aids and adaptations for health and social care. It helps to facilitate prompt hospital discharge and independent living in people's own homes, and support disabled children at school. Accessed by district nurses, occupational therapists and social workers, it has enabled more effective and efficient use of equipment across the county, supporting service development and delivery of improved health and social care outcomes. Savings include management costs and greater efficiencies derived from joint purchasing power.

Source: Audit Commission 2009 [10].

such impositions, the proposal (via 'personal budgets') to increasingly devolve real budget-holding to individual service users could reduce the commissioning role of LAs and complicate the commissioning landscape.

The relationship between competition and collaboration has been ostensibly addressed by the creation of the ominously sounding Cooperation and Competition Panel which investigates and advises the Department of Health, but its work is confined to acute hospitals and seems to focus on promoting competition rather than encouraging cooperation. Ham [15] argues that its attention is almost entirely focused on extending patient choice, stimulating greater plurality of provision, and developing incentives to support a bigger role for markets. More broadly, as Wistow et al. [14] notes, to the extent that the policy framework is incomplete or unclear, improvements in technical commissioning capabilities will be of limited value.

This ideological duality is continuing with the new Coalition Government which in June issued a new White Paper on the future of the NHS [16]. Although proposing to develop new forms of joint working between the NHS and local government—most notably by the creation of new local Health and Wellbeing Boards—-the White Paper also sees the creation of choice and the promotion of competition as the prime goals of a reformed system. To this end far greater freedoms are proposed for the acute sector, including more autonomy over governance and fund-raising. Importantly, the White Paper also proposes that, for the first time, acute care providers should be empowered to provide social care themselves, as opposed to forming a partnership with local authorities. The political stage is therefore set for a tussle between horizontal and vertical integration.

2.2. Organisational turbulence

Both local government and the NHS have been subject to organisational restructuring over the past decade, but this has been more pronounced in the case of the NHS. To some extent this has been beneficial to joint commissioning since there has been a general aspiration to move towards coterminous boundaries between LAs and PCTs which might be expected to facilitate joint working. However, the local commissioning agencies of the NHS have changed drastically over the past decade. In 2001, there were around 500 commissioning Primary Care Groups designed to fit with GP practices, but the cost and ineffectiveness of these agencies soon led to a reduction in numbers—down to around 300 by 2003 and about 150 by 2006 (by which time they had been rebadged as Primary Care Trusts). The latter figure had the benefit of almost matching the number of LAs, but in the new NHS White Paper the Coalition Government is now proposing to abolish *all* PCTs and move towards a system of General Practitioner Commissioning Consortia potentially numbering around 500 across the country.

This is not simply a matter of numbers and administrative boundaries: it is also about the inter-personal relationships upon which so much joint working is based. All restructuring exercises damage networks, but the latest proposal to abolish the main NHS commissioning organisations of the past decade (PCTs) for a new and largely untried alternative (GP Consortia) will be especially damaging. Each restructuring not only destroys established networks, but it also re-focuses energy and attention upon internal reorganisation rather than external relationships. The cultural damage created by this endless change is rarely assessed. Rather the restructuring model is based upon a formal, hierarchical and mechanistic view of how organisations work, which downplays the importance of culture, norms, values and relationships [17, 18].

2.3. Performance management frameworks

One of the most common dilemmas of the past decade is that *local* attempts to work jointly have been under-

mined by separate performance management arrangements at the *centre.* As the Audit Commission notes:

> "*Assessing the impact of partnership working is not straightforward given the absence of meaningful national indicators covering both health and social care*" [10; p. 6].

Carefully crafted performance frameworks have the capacity to bind different services together around common outcomes and objectives, just as weak and divisive frameworks can undermine such efforts. Contributors to the Audit Commission report (*op cit*), for example, referred to:

> "*Numerous sets of joint commissioning guidance issued at similar times by different government departments and other national organisations… They also pointed to different priorities, contract monitoring processes and performance indicators, which can lead to duplication and a lack of shared outcomes*" [10; p. 49].

This constitutes a specific example of a more general problem discussed by Parker et al. [19], that the efficacy of many local partnership mechanisms has been seriously limited by central government 'departmentalism'. In the absence of more joined-up working at central level, joined-up initiatives at local level will always struggle to make an impact. The new Coalition Government sees a common focus on 'outcomes' as a way of addressing this difficulty, and as part of the NHS White Paper consultation process it has produced a draft framework for the articulation and measurement of NHS outcomes [20]. However, although acknowledging that some of the NHS outcomes cannot be achieved without a significant contribution from local government (especially social care), the intention still appears to be to develop a separate outcomes framework for health and social care, respectively—a missed opportunity for integration.

2.4. Power imbalances

Despite the political and ideological significance attached to the purchaser-provider split in England, there has been surprisingly little attempt to nurture commissioning skills and strengthen the commissioning role; rather the focus of policy attention has been upon *providers*. Indeed, a recent investigation into commissioning health care by the House of Commons Health Committee arrived at the conclusion that after 20 years of the purchaser-provider split, commissioners remain passive and poorly placed to improve quality and offer a challenge provider organisations. It starkly suggests that:

> "*If it does not begin to improve soon, after twenty years of costly failure, the purchaser-provider split may need to be abolished.*" [21, paragraph 202].

One fairly recent attempt to boost the health commissioning role has been the introduction by the Department of Health [22] of its 'world class commissioning' (WCC) programme. The overriding objective of WCC is said to be to transform the way health *and care services* (italics added) are commissioned. WCC, it is said, will deliver better health and well-being for all in that people will live healthier and longer lives and health inequalities will be dramatically reduced. Further, it will deliver better care for all—services will be evidence-based and of the best quality, and people will have choice and control over the services that they use. In all of this, it is said, PCTs will work with others to optimise effective care, most obviously with LAs. In practice, as the Audit Commission report [10] has noted, WCC has become a 'tick-box' internal NHS preoccupation that fails to recognise the importance of genuine partnership working [23].

However, this weakness of the commissioning role has to be set alongside the strength of the providing role, especially in the case of the key health providers—general practitioners (GPs) and clinicians in acute hospitals. In effect, GPs make resource allocation decisions by deciding to refer patients to hospitals and commissioning PCTs have been relatively powerless to prevent these decisions. At the same time the payment by results policy in acute care provides hospitals with an incentive to generate more activity to increase their income, and PCTs have not found it easy to control the volume of clinically determined admissions and internal (consultant to consultant) transfers. Also those individuals who feel they need urgent treatment have continued to refer themselves to Accident and Emergency facilities in hospitals regardless of appropriateness. PCTs then, as the formal commissioners of health care, are left in the position of having little control over volumes of activity for which they are financially liable—the unenviable situation of responsibility without power.

The weakness of the PCT health commissioning role means that the potential for commissioning jointly across health and social care with LAs is correspondingly weakened. It is further hampered by a mismatch between *levels* of commissioning across the two sectors—social care commissioning increasingly takes place at the level of the individual professional (care management), service user (personal budgets) or small independent sector provider, whilst health care commissioning has been with a small number of large acute hospitals. Also, as Wistow et al. [14] have observed, while LAs have developed strong *contracting* functions with the independent sector, this is only part of the commissioning cycle. Strategic commissioning of social care by LAs remains relatively undeveloped.

The *raison d'etre* behind the proposal in the new NHS White Paper to hand over the bulk of NHS commissioning to GPs is partly based upon the belief that they will be better placed to control what goes on both within general practice and in the acute sector. It is far from clear that this will be an effective strategy. It is equally unclear what the implications of this shift will be for *joint* commissioning between GPs and local government—a partnering arena with no history and no obvious structures or networks.

3. Where next for joint commissioning: a new policy paradigm?

The imperatives identified in Box 1 still pertain, therefore (in the absence of even more structural reorganising) the issue is not whether to abandon joint commissioning but rather how to make it work. The answer may lie less in specific programmes and initiatives, and more in rethinking models of policy formulation and implementation. The last decade (and earlier) of policy-making in England has been characterised by a set of assumptions about the virtue of 'top-down' decision-making and policy implementation as a means of policy accomplishment. As Hill and Hupe have noted, even when policy formers are confronted with disappointing results, their standard reaction will be to take additional measures aimed at stricter implementation—"*the outcome of disappointing policy results will be more policy*" [24; p. 168].

In his seminal formulation of 'perfect policy implementation', Gunn [25] identifies the following components:

- sufficient time and resources
- no major external constraints
- a small and well-defined chain of command
- a single implementing authority
- clear understanding of the desired outcome
- agreement among all of those involved on aims
- perfect communication

It is clear that these conditions do *not* apply to joint commissioning across the organisational and professional boundaries spanning health and social care. On the contrary, this policy domain involves a differentiated polity characterised by significant areas of autonomy from the centre and operating through policy communities and networks [26]. This suggests the need to think about policy implementation as varying in relation to the character of the policies to be implemented, and to understand joint commissioning as a 'wicked issue' [27] characterised by problem complexity, lack of consensus and institutional complexity.

Given this conceptualisation of the type of policy, and given the failure of top-down models as described above, how can a different approach to joint commissioning be formulated? The answer may be to focus less upon legislation and organisational structures and restructures, and more upon the relationships between the front-line managers and professionals who (in effect) are taking many of the commissioning decisions anyway—an emphasis upon networks rather than hierarchies, and upon *patterns* or 'pathways' of care rather than *episodes* of care.

The notion of a '*pathway of care*' is not new, especially in clinical circles where it is used to denote task-oriented care plans which detail essential steps in the care of patients with a specific clinical problem, and describe the patient's expected clinical course. These offer a structured means of developing and implementing local protocols of care rooted in evidence-based clinical guidelines, and provide a means of identifying the reasons why care may fall short of adopted standards [28]. Typically, these pathways are clinical in orientation and restricted to a single treatable condition.

A more ambitious model is that of '*managed clinical networks*'. This model is envisaged as a means of linking health care personnel working across professional and organisational boundaries to deliver care for a specific condition or perhaps for a specific set of services. Such networks have been used to attempt to deliver coordinated care for a wide range of conditions, notably cancer, stroke and diabetes. Compared with care pathways, this model incorporates an appreciation of the need to work across a wider range of boundaries, including non-clinical partners, and may encompass the integration of *services* as well as professionals.

A further step in ambition is that of a '*managed care network*'—a similar arrangement to a managed clinical network but one in which the focal issue is more complex (e.g., independence and wellbeing), and the range of partners commensurately broader. Critically the focus explicitly goes beyond health services and clinical care—a concern with not so much a single condition or even the 'whole patient' but the '*whole person*'. This, in turn, requires an understanding of—and 'networking' across—the '*whole system*' [29, 30].

Wistow et al. observe [14] that this process is one of co-design between users, carers and community interests, as well as professional stakeholders, and can provide a framework within which to align:

- prevention, early intervention, care, treatment and enablement
- personalisation

- public health, primary care, community health and acute services
- social care and wider LA responsibilities for community wellbeing
- local government, the NHS and other sectors.

The specific ways in which such networks might be established and governed would require further exploration, but two broad parameters will need to be established. First an acceptance of some flexibility in how they will work—learning from the limitations of top-down, command and control models. Although the concept should be explicit in mapping out potential routes from 'beginning to end', there will be various 'stopping routes' and choices along the way to reflect differences in needs and preferences [31]. This flexibility is a corollary of moving away from rational, linear and reductionist thinking towards the management of complex adaptive systems focused upon 'emergent' solutions that seem to work best in the circumstances [32]—what works is a product of what seems right in a particular place at a particular time.

The second parameter is around accountability. Some management of emergent networks will be essential, but this will need to be on a much less hierarchical basis, with a form of management that is *facilitative* rather than based upon command and control [33]. Ensuring the accountability of the care networks could be the future role for the local Health and Wellbeing Boards proposed in the new NHS White Paper.

4. Conclusion

This article has explored the joint commissioning of health and social care in England over the past decade. It has noted the contrast between the aspirations that arose in the wake of the purchaser-provider split across both policy domains, and has contrasted this with the relatively limited achievements. The conclusion to emerge from the analysis is that even in a highly centralised state like the UK (and more specifically England), there are severe limits to what can be achieved through top-down, command and control systems to encourage joint working. In part this is caused by ambiguous and conflicting policy messages, but primarily it is a model that ignores the *de facto* power of front-line professionals, especially clinicians.

It has been argued that a better approach would be to go with the grain of professional discretion, but to do so in a way that structures this role, extends the range of stakeholders to individuals and communities, and develops new forms of accountability. Changing the policy paradigm in this way is hugely challenging and it will be important to remember the conclusion to emerge from Ferlie and Pettigrew's review of network organising—that network building is a long-term, emergent and developmental process which may conflict with a short-term and task-oriented approach to management [34]. But to do nothing would be to fall into trap identified in the well-known aphorism—that those who fail to learn from history are doomed to repeat it.

5. Reviewers

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Glossary of terms

Primary Care Trusts: The local organisations currently responsible for commissioning health care. They are held to account at a regional level (by Strategic Health Authorities) and then centrally to the Department of Health.

Local Authorities: Democratically elected local bodies responsible for (amongst other things) commissioning social care services.

Joint Strategic Needs Assessment: Section 116 of the Local Government and Public Involvement in Health Act 2007 requires PCTs and local authorities to produce a JSNA to describe the future health, care and well-being needs of their local community, and the strategic direction of service delivery to meet those needs.

Payment by Results: Payment by Results was announced in 2002 by the Department of Health as a way of reimbursing hospitals in England for the activity they carry out (for example, patient episodes, outpatient attendances and diagnostic tests). It uses a national tariff of fixed prices that reflect national average costs.

Pooled Budget: PCTs and local authorities each make contributions to a common fund to be spent on pooled functions or agreed NHS or health-related council services under the management of a host partner organisation.

Personal Budget: A personal budget for social care can be taken by an individual as a direct (cash) payment, as an account held and managed by the local authority in line with the individual's wishes, or as an account placed with a third party provider and used by the individual as and when the need arises. It is seen as a key means of empowering service users.

Care Trust: An NHS care trust, is a type of NHS trust in the National Health Service of England and Wales that provides both health and social care. They may carry out a range of services, including social care, mental health services or primary care services.

Foundation Trust: NHS foundation trusts (often referred to as foundation hospitals) are a relatively new type of NHS trust in England. It is said they will devolve decision-making from central government control to local organisations and communities, so they are more responsive to the needs and wishes of their local people.

Cooperation and Competition Panel: The Panel monitors observance of the Principles and Rules of Co-operation and Competition for the provision of NHS-funded services. It investigates potential breaches and makes independent recommendations to the Department of Health on how such breaches should be resolved. It also reviews proposed mergers, and advises on the wider development of co-operation, patient choice and competition within the NHS.