

viewpoint

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Reconsidering  
accountability  
in an age  
of integrated care

Ben Jupp

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## About this Viewpoint

**Nuffield Trust Viewpoint papers provide a platform for UK and international health leaders to explore, discuss and debate critical health care reform issues.**

This Viewpoint, from Ben Jupp, who has worked on public service strategy across a number of services, comes at a critical time for the NHS and social care system, with the Conservative Government taking forward a number of manifesto commitments to reform care services.

It focuses on an issue that has received little examination in recent times: the implications for the accountability of local care services that arise from the new integrated models of care that are being developed following NHS England's *Five Year Forward View*. The paper is preceded by a foreword from Andy McKeon, Senior Policy Fellow at the Nuffield Trust, and followed by a set of expert responses from others working in health policy.

The paper has been informed by conversations between Ben Jupp and health and social care policy-makers, practitioners and academics; an expert seminar at which the ideas outlined in the paper were tested and developed further; and the author's own experience of engaging with other sectors, such as education, where similar accountability questions have been raised.

Visit the publication webpage for additional materials, including blogs from various commentators in response to the Viewpoint, at: [www.nuffieldtrust.org.uk/publications/reconsidering-accountability-integrated-care](http://www.nuffieldtrust.org.uk/publications/reconsidering-accountability-integrated-care)

The Viewpoint forms part of the Nuffield Trust's work programme on NHS reform – you can view other research, policy analysis and interviews with health leaders on this topic on our website at [www.nuffieldtrust.org.uk/our-work/nhs-reform](http://www.nuffieldtrust.org.uk/our-work/nhs-reform)

The views expressed are the authors' own, written in a personal capacity, and do not necessarily represent those of the Nuffield Trust, or Ben's employer, Social Finance.

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## About the author

Ben Jupp has many years of experience supporting the developing policies and programmes to improve the delivery of better public services. He worked in the civil service for 10 years, including as Director of Public Services Strategy and Innovation, reporting jointly to the Minister for the Cabinet Office and Chief Secretary to the Treasury; as head of strategy at the Home Office; and as Director of the Office of the Third Sector. For the last five years Ben has been a director at Social Finance, arranging socially motivated investment into new models of provision in health, social care and children's services. He is a Senior Visiting Fellow at the Nuffield Trust and also holds non-executive roles in education and social care.

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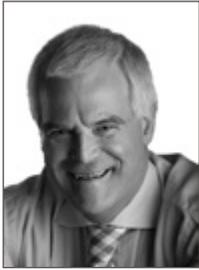
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# Foreword

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Andy McKeon  
Senior Policy Fellow,  
Nuffield Trust

Ben Jupp's paper on accountability issues in health and social care is very timely. His experience in central government and public sector reform make him ideally placed to address the subject. The points he raises demand early debate.

For over a quarter of a century, the purchaser–provider split has been the foundation stone of NHS structures, policy and accountability arrangements. But the proposals for new local service models in the *Five Year Forward View* published by NHS England in October 2014 suggest new arrangements – with integrated acute and primary care provider organisations with a capitated budget becoming responsible for the care of a local population or primary and community services merging to do the same for at least a subset of such care.

Both are at odds with the purchaser–provider split and the current arrangements whereby clinical commissioning groups composed mainly of GPs are responsible for commissioning most community and secondary care for their local population from a range of separate providers contracted through different payment mechanisms, often under competitive principles.

At the same time the financial and demand pressures on social care grow ever more intense. Since 1948 there has been a clear division of responsibilities, funding and accountability arrangements with social care essentially local and health care national. But these long-standing arrangements begin to look outdated as the Government lays down a new national framework of entitlement to social care, local authority care becomes increasingly dependent on NHS funds and the move for greater integration of health and social care services gathers momentum, including at a city-region level in Greater Manchester and elsewhere.

Accountability arrangements are critical to any system. They set the framework for strategic decisions about how services are provided and to whom, the quality of those services and whether the funds available are well spent. They determine how much say local people and users have alongside regulators and national and local politicians. Weak, poorly designed accountability arrangements are likely to lead to strategic or service quality failures or poor value for money.

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The pace of change over the next five years will need to be rapid if the NHS is to save at least a fifth of its budget and meet the care requirements of rising numbers of elderly people. Integrating with social care will be a dominant theme. The pressure will be on to establish new organisational structures and models of care locally. Getting the accountability arrangements right – and avoiding a bureaucratic fog – will be critical to providing clarity for those leading organisations and longer-term success.

National and local politicians and health and social care leaders could begin by articulating the framework and principles that should guide the new local developed approaches and, in doing so, answer some important questions. For example, should provider organisations responsible for the care of a local population have greater formal public involvement than, say, foundation trusts do now? How should such organisations be regulated?

The Nuffield Trust, which has funded this report, is grateful to Ben for the work he has put in and his willingness to discuss emerging thoughts with the Trust. We are also grateful to those within health and social care and more widely who have considered the issues Ben raises and helped to shape his thinking.

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# Reconsidering accountability in an age of integrated care

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# Introduction

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Ben Jupp is a Senior Visiting Fellow at the Nuffield Trust. He has previously held the role of Director of Public Services Strategy and Innovation in the Cabinet Office.

It has become almost customary in recent decades for each new or returning government to announce new health and social care legislation. This year's State Opening of Parliament was a notable exception. After the controversies of the 2012 Health and Social Care Act, there is no political appetite for further major national structural reform. The direction of travel set out in NHS England's *Five Year Forward View* was reaffirmed in the Conservative Party manifesto (Conservative Party, 2015) and the Secretary of State for Health, the Rt Hon Jeremy Hunt MP, has remained in place.

Yet I believe that, in practice, by the end of this Parliament the system of governance and accountability in England's NHS and social care system may well have commenced changes that in the long term will be more profound than during the previous Parliament, despite a lack of planned legislation. The development of new models of integrated care set out in the *Five Year Forward View* (NHS England, 2014a) has the potential to redraw the boundaries between the functions of commissioners and providers of care – the 'purchaser–provider split' – that have characterised the system since the late 1980s. Big change could be afoot in primary care as practices merge or federate and take on new services. For local authorities, the implementation of the 2014 Care Act and severe budget cuts may catalyse the need for a new system of shared accountability across the NHS, central government, or within city regions.

The *Five Year Forward View* vision of change being locally determined and often evolutionary has enormous attractions. It offers the scope for approaches to be tested and refined and, ultimately, to be more sustainable. Yet, precisely because the developments are incremental and local, some significant decisions may not receive the debate and challenge they deserve – or that they might have had if they had been the result of legislation.

This paper therefore seeks to explore how current policy and emerging ideas could drive changes in accountability. It discusses the choices and challenges these changes present. Issues explored include the following:

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1. The **governance of integrated providers** outlined in the *Five Year Forward View*, such as Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACs), will need to develop if they absorb both elements of commissioning and provision functions – particularly those that have grown out of general practice.
  2. If providers have more power to define the services they deliver to users, the **roles of inspectorates and regulators** are likely to grow further in importance. This has been the experience in education, for example, where Ofsted plays an ever more critical role as the oversight of local authorities has diminished.
  3. Maintaining the stability of clinical commissioning groups (CCGs) is sensible in the short to medium term. However, in the long term **CCGs may need to radically evolve from their current form** if accountable care organisations (such as the *Five Year Forward View* integrated care models) take on most of the population health management responsibilities. Restricting membership of CCGs to GP practices could also look increasingly anomalous and be subject to irreconcilable conflicts of interest if integrated provision becomes the norm.
  4. **Local elected councillors and local authority leaders face some of the biggest choices as they seek to increase the accountability of health and care to their local populations.** The joining up of elements of health and care, transfer of public health to local government and establishment of Health and Wellbeing Boards have given councillors and local authorities more of a voice in health over the last few years. I consider that such local representation is to be welcomed. However, over the coming Parliament, the unprecedented expected squeeze on local government resources and the more nationally determined framework for social care has the potential to undermine this influence unless local authority leaders think creatively about the powers and democratic representation they can bring to bear.

This paper seeks to prompt questions. They do not need to be answered immediately, but it is important to recognise that the precedents that are set over the next few years may well determine the landscape of governance and accountability for the long term.

# What is public accountability in health and care?

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“Precisely because the developments are incremental and local, some significant decisions may not receive the debate and challenge they deserve – or that they might have had if they had been the result of legislation.”

With publicly funded health and social care now responsible for nearly £1 in every £5 of government expenditure (and over 8 per cent of GDP) and a good health service topping people’s political concerns, those making decisions and leading delivery of services are understandably scrutinised (Emmerson and others, 2015; The Economist and Ipsos MORI, 2015).

The NHS and publicly funded social care are important not only for people’s individual wellbeing, but also to the health of the population, the fairness of our society, levels of taxation and economic growth. Hence, although it may be tempting to argue that health and care decisions should be left solely to clinicians and patients, it is surely right that services are accountable to the public.

I find it helpful to think about accountability for public services as having three, inter-related elements (Brinkenhoff, 2003):

1. accountability for strategic decisions on provision and the allocation of resources, particularly which services are provided and to whom
2. accountability for the quality of services delivered – such as access, clinical quality, safety and outcomes
3. accountability for the management of resources – including value for money, probity and fairness.

All three elements are important. Over the next few years, for example, it will be crucial to hold services to account for how they respond to challenges such as:

- how services develop to reflect emerging needs, such as addressing the challenge of care for the rapidly rising number of people with dementia
- how health and care services can be better integrated among themselves to provide more seamless care, and with other public services such as employment support, housing and leisure to better prevent ill-health
- how an ethos of quality becomes further embedded across all care after some high-profile failures in recent years

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“The critical feature of the present accountability structure is that its formal locus is in commissioning.”

- how leaders take some very difficult resourcing decisions, including making best use of the additional £8 billion promised to the NHS and how to respond to an unparalleled productivity challenge.

Delivering each element requires clarity on who should be held to account and how decisions are made; good information on how services are performing; and simple mechanisms for rectifying problems if these arise. For public services such as the NHS and the social care system, the systems of governance also need to ensure that decisions genuinely reflect the priorities of services users, and build people’s trust.

For the sake of brevity it is not sensible to describe every element of today’s mechanisms for seeking accountability in health and care, let alone their strengths and weaknesses: in the course of writing this paper I have heard strong arguments both that the NHS has insufficient accountability and that it fails to sufficiently trust managers and professionals without bureaucratic oversight, both of which probably have some truth.

However, it is worth highlighting that **the critical feature of the present accountability structure is that its formal locus is in commissioning.**

Under the current framework the Secretary of State for Health is accountable to Parliament for the health system in England as a whole, including NHS England as its ‘steward’, for determining levels of resource allocations, high-level objectives and overall performance (Department of Health and NHS England, 2014). The Department of Health highlights that beneath this system-level responsibility of the Secretary of State, “the principal line of accountability for the NHS is through the commissioning line, following the flow of money from DH to NHS England to CCGs” (Department of Health, 2014). The aim is that each level in this commissioning chain – NHS England and CCGs – has independent responsibility and that providers are primarily held to account through contracts.

Other elements of the system, including the governance of NHS trusts, regulation, inspection and redress, have supporting roles. While giving patients choice over the services they use has the potential to make these services more directly accountable to

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their users, it is noticeable that patient choice has not been as powerful an incentive for service improvement as the Government anticipated when choice was expanded significantly in the early and mid 2000s.<sup>i</sup>

In social care, local government is responsible for delivery, although central government has an important role in setting strategic outcomes for the system nationally (see, for example, Department of Health, 2013). As with health, local authorities now discharge these responsibilities primarily through commissioning and the use of contracts, alongside some residual direct delivery and the delegation of some users’ funding to personal budgets.

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i The public services reform model developed by the government during Tony Blair’s second and third terms as Prime Minister envisaged that service improvement would be driven by three types of incentive and elements of accountability: upwards accountability to government; horizontal accountability to regulators and inspectors and through competition from other providers; and choice and voice by users (see, for example, Cabinet Office, 2006). Although choice has been expanded significantly in health, it is noticeable that in most elements of health care people have not exercised a choice to go to alternatives to local providers. It is interesting to note that the Secretary of State for Health recently expressed the view that patient choice is not the main driver of performance improvement given that health provision often includes natural monopolies (West, 2014).

# What impact will new models of integrated care have?

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The development of new models of integrated care potentially represents a significant shift in this system of commissioning.

The *Five Year Forward View* outlines various delivery models that aim to improve care and drive productivity by aligning and integrating primary care, community care, mental health, acute care and potentially social care. As many readers will be familiar, the focus is on two models: MCPs and PACSs. MCPs will be primary care practices (or federations) that employ or contract in nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care. The aim will be for MCPs to shift “the majority of outpatient consultations and ambulatory care to out-of-hospital settings” and they may take responsibility for community hospitals and diagnostic services (NHS England, 2014a: 19). PACSs will develop ‘vertically’ integrated care by allowing hospitals to deliver primary care services, or potentially over time by merging with MCPs.

To me, the interesting feature of these models, and the reason that I believe they have a good chance of being sustainable, is that they build on practice which has already started to emerge. GP practices, such as the Whitstable Medical Practice and the Vitality Partnership, have already grown to a significant scale and offer an increasing range of specialist services such as consultant-led clinics (Smith, 2013). It is telling that, in the *Health Service Journal's* CCG Barometer surveys in 2014, even before the *Five Year Forward View*, the vast majority of respondents envisaged commissioning significant additional services from GPs in the next 12 months. Over 70 per cent also expected the majority of GPs in their area to join a single provider organisation in the next four to five years (*Health Service Journal*, 2014).

Torbay’s plans for an integrated care trust is another example of practice preceding the policy. Torbay and Southern Devon Health and Care has successfully provided integrated community health and social care services for many years, and is now in the process of merging with the local acute trust (South Devon Healthcare NHS Foundation Trust). Although they do not provide primary care, they are starting to bring together the elements required for good vertical integration.

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“The interesting feature of [the new models of integrated care] ... is that they build on practice which has already started to emerge.”

The *Five Year Forward View* implementation through 29 ‘Vanguard’ sites, additional funding and new flexibilities offers the scope to significantly accelerate this process. There are certainly major challenges in implementing these new models, and they are still in their infancy, but in my view they represent a genuine opportunity to improve outcomes and deliver greater value for money.

The models also have the potential to transfer responsibility for population health and budgets onto providers. As the *Five Year Forward View* acknowledges, “a combined health and social care budget could be delegated to Multi-specialty Community Providers” (NHS England, 2014a). More broadly, they form part of a wider shift towards capitation payments rather than fee-for-service tariffs, as the system looks to introduce incentives to better manage long-term conditions (Appleby and others, 2012; Charlesworth and others, 2014). Under capitated arrangements, a total package of funding is allocated to a provider, often on an annual basis, based on the number of people they are responsible for, whether or not these people receive treatment.

NHS England Chief Executive Simon Stevens recently played down the significance of these changes, suggesting that in the future clinicians may simply ‘internally’ undertake the same commissioning activities as they currently undertake ‘externally’ as members of CCG governing bodies (Nuffield Trust, 2015). However, the original vision for commissioning – rightly or wrongly – was that much of the benefit arises from a contractual separation in the specification of a service and its delivery. Integrated care, with capitated and population budgets, represents a big departure from this model.

### Lessons from other sectors and countries

Nor is this merging of local commissioning and provider functions, and the development of capitated budgets, confined to health and care. For example:

- Over the last few years, schools have taken an ever more important role in determining total provision for their pupils, using a capitated and increasingly nationally determined minimum-per-pupil budget (Department for Education, 2014a). The role of local authorities in holding them to account and

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“The original vision for commissioning was that much of the benefit arises from a contractual separation in the specification of a service and its delivery.”

purchasing specialist support has diminished enormously, and academy schools in particular have wide-ranging freedoms to operate independently within a national framework (Department for Education, 2015).

- Employment support used to be partly commissioned locally for those whose needs extended beyond the advice available from a Job Centre. That patchwork of locally commissioned services has now been largely replaced by a few large prime contractors, operating under long-term contracts, who take responsibility for people’s employment support needs in the round and decide how much to deliver themselves and how much to sub-contract to specialist service providers. The rationale of the Department for Work and Pensions is that “providers are best placed to identify the most effective way of helping people into sustained employment” (Department for Work and Pensions, 2012: 3).
- The prison and probation system never introduced a full purchaser–provider split, but under the recent ‘Transforming Rehabilitation’ programme, sub-regional prime providers are taking responsibility for cohorts of offenders, with payment based on a mixed capitation and payment-by-results basis (Ministry of Justice, 2013).

Other health systems are moving in a similar direction: Alzira in Spain and accountable care organisations in the US are both good examples of this and have been much discussed in the context of the new models of care developing in England. The Spanish health care system now enables lead providers to take responsibility for the full range of health services and infrastructure in an area. These long-term ‘administrative concessions’ involve the provider working to a capitation-based budget, usually for a period of 15 years or more, with the scope to refine the service over time in partnership with the municipality. Results have been promising (NHS European Office and NHS Confederation, 2011). In the US, accountable care organisations have developed as a way for Medicare/Medicaid, and increasingly private insurers, to stimulate the integration and efficiency of services. Under this approach, lead providers or partnerships take collective responsibility for the quality and costs of care delivered to specific cohorts. In a similar way to the UK, a number of models are developing – some led by primary care (akin to the MCP model) and others by hospitals

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(akin to the PACS model). It is still early in the development of accountable care organisations, and there have been some mixed initial results from the integrated care pioneers. However, the hope is that by providers ‘owning’ the integration collectively, a simple system of financial incentives (sharing savings between providers and Medicare) and focusing equally on quality and costs, the impacts will be greater than previous attempts at managed care (Shortell and others, 2014). Scotland and Wales have also moved away from a purchaser–provider split, and although Northern Ireland has a commissioning system, provision is largely managed by integrated health and care trusts.

I believe that we may be witnessing, therefore, a shift in the orthodoxy of public service management and accountability, of which the *Five Year Forward View* models are just one part. Rather than assuming that the detail of a public service should be independently specified by a ‘purchaser’ who then contracts with a ‘provider’ – often following a competitive procurement – lead providers are increasingly considered best placed to develop packages of care and support.<sup>ii</sup> The aim is to better infuse planning with front-line insight, enable more innovation and flexibility than traditional contractual relationships allowed, and to avoid some of the risks of fragmentation. Oversight, accountability and incentives for performance are increasingly being sought through a strategic commissioning or funding framework that involves longer-term contracts or concessions, funding formulas, the measurement of outcomes and an inspection/assurance process.

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ii It is also important to recognise that under the ‘Any Qualified Provider’ framework and other mechanisms to increase choice, providers already have some freedoms to design how services operate.

# What changes are likely to occur in social care?

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The trajectory for the management of social care provision is more complex, but the role of the local commissioner as the primary locus of accountability for delivery could also be set to evolve.

I think that it is helpful to consider the management of social care being driven by three long-term drivers of change.

The first is a gradual transition towards a **more personalised approach to care**. Giving people greater choice and control, including through expanding personal budgets, has been a key objective of local and central government for many years. The 2014 Care Act looks to further embed a national framework for personalised care by introducing a more common method for assessing individuals' need and allocating resources.

Secondly, local authorities are **finding financial pressures in social care** increasingly difficult to absorb on their own. Without a further increase in care thresholds or major reductions in the quality of care, the Local Government Association (LGA) and Association of Directors of Adult Social Care (ADASS) predict a 'gap' in social care funding of £4.3 billion by 2019/20 (Downs and Pearson, 2015). Given that the scope for raising additional local revenue is extremely limited, authorities' flexible Revenue Support Grant is projected to fall by more than a quarter over the Parliament, and the introduction of new national minimum entitlements to care reduces the scope of authorities to restrict funding to individuals, it is hard to take the view that this gap can be addressed primarily at a local level. I think that, in practice, central government or the NHS will need to pick up greater responsibility for funding elements of social care. The £3.8 billion Better Care Fund and £335 million of central government funding for implementing the Care Act in 2015/16 arguably already reflect this position.

The third trend is the need to **integrate some elements of social care with health**, particularly for older people with co-morbidities. Such integration may be through the *Five Year Forward View* integrated care models or more bespoke packages of joined-up support. This in turn raises questions about whether and how funding should be brought together. While various joint commissioning arrangements between health and care have developed over the last few years, and some studies have cast doubt

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“In practice, central government or the NHS will need to pick up greater responsibility for funding elements of social care.”

on the importance of integrated funding per se (Audit Commission, 2009), the development of integrated models of provision clearly strengthens the case for a further integration of budgets.

Together, these three trends have the potential to challenge the traditional model of local authorities as solely responsible for the vast majority of social care. In practice, responsibility is already being increasingly shared with the NHS for some groups. However, my view is that it is not yet clear whether an alternative, simple model of accountability will emerge. For example, drawing on the Commission on the Future of Health and Social Care, The King’s Fund argues for a single budget and single local commissioner for health and care, probably based on reformed Health and Wellbeing Boards. However, it also notes considerable nervousness within the NHS over transferring resources in such a manner (Humphries and Wenzel, 2015). Another option is that central government gradually takes greater accountability for an integrated health and care budget as it is forced to meet funding gaps. Yet greater formal central accountability for social care would both cut against ambitions for devolution and make ministers responsible for what will inevitably be a set of very difficult choices on funding – choices which many ministers may understandably wish to leave at local level.<sup>iii</sup> A further permutation may be the integration of funding through personal budgets that cover health and care, as the NHS is currently piloting.

My sense, therefore, is that local authorities will need to continue to follow the pattern of recent years of increasingly sharing accountability for elements of social care with others: with individuals through personal budgets; with integrated providers who may take over responsibility for care planning and even budgets; and with the NHS and central government.

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iii Perhaps to address this dilemma, ADASS (2015) argue for new ‘protected’ social care funding but without a formal ‘ring-fence’ and alongside the strengthening of local accountability mechanisms.

# What are the main implications and what choices do policy-makers face?

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In my opinion, today's system of accountability for health and social care, resting primarily with CCGs and local authorities, has enough flexibility to accommodate many developments in the short term. The Greater Manchester plan for an integrated health and social care budget, for example, envisages no formal changes in accountability – with CCGs and local authorities simply pooling resources and decision making through standard 'Section 75' agreements (Association of Greater Manchester Authorities, 2015). A period of experimentation and learning has considerable attractions.

There are, however, important questions that are likely to emerge over this Parliament.

## 1. How best to strengthen provider governance?

New models of integrated provider, with responsibility for planning population health and the use of capitated budgets, could accrue many of the functions that CCGs hold today and develop a local dominance which enables them to set their own direction. In social care, the transition to a fully personalised approach may well also increase the power of some independent providers as the leverage of local authorities diminishes. Providers may also face greater financial risks if they assume responsibility for population budgets.

In my view, primary care is probably the element of the health and social care system with the least developed system of public accountability at present – with little public ownership, limited contract management, limited financial transparency and limited market pressures since relatively few patients switch practices. While this approach could be considered proportionate in a period when most practices were small and focused on a limited range of activities, the pattern of provision could potentially change quickly with the rise of larger practices and MCPs.<sup>iv</sup>

More broadly, if the experience of employment services and justice services is replicated in health care, large commercial prime

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<sup>iv</sup> For example, organisations such as The Practice now hold contracts for over 50 GP surgeries.

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“If the experience of employment services and justice services is replicated in health care, large commercial prime providers could be well placed to play a more significant role in the delivery of integrated care.”

providers with balance sheets to withstand considerable risk and significant experience of analytics and supply-chain management could be well placed to play a more significant role in the delivery of integrated care. While such a model of commercialisation is not inevitable – NHS trusts continue to have some significant strengths, and have advantages as the incumbent acute providers – it is worth considering whether such private sector provision would lead to new accountability challenges. For example, while the overall evidence on the relative merits of public, private and not-for-profit care is inconclusive, experience in the US suggests purely commercial providers tend, unsurprisingly, to focus on providing services to more profitable segments of the population.<sup>v</sup> The role of foundation trusts’ boards, governors and members in the NHS accountability system would also diminish markedly.

Should policy-makers therefore look again at how the governance of providers themselves could be strengthened as their responsibilities widen, to enable more direct public accountability for strategy, quality and value for money?

Following the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013), a number of developments to enhance provider governance and accountability are already in train. For example, directors need to meet a Fit and Proper Person Test. Provider organisations must articulate a statement of purpose. A new duty of candour has been introduced for all staff.

However, as the new integrated provider Vanguard models outlined in the *Five Year Forward View* are developed, service leaders should look carefully at the precedents for provider governance that are being set, particularly for MCPs, and particularly if whole-population capitated contracts are put out to tender.

An important question is whether not-for-profit or social purpose organisations should be favoured in new primary care-led models, and likewise for NHS providers (or at least social purpose providers)

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<sup>v</sup> The pros and cons of for-profit and not-for-profit health care providers generates considerable debate and the literature is not definitive and usually based on the US health care system. It is therefore not directly comparable with the UK. However, a number of studies find associations between non-for-profit status and the range of services offered, groups and aspects of quality (see, for example, Horwitz, 2005; Comondore and others, 2009).

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“An important question is whether not-for-profit or social purpose organisations should be favoured in new models of care.”

for vertically integrated providers. As other service provider landscapes have undergone transformations in different sectors over the last 30 years, this question has been answered very differently.

In education and children’s services, both Labour and Conservative Governments have required most new providers to be not for profit. The recent Conservative Party manifesto, for example, renewed the commitment for all academy schools to be overseen by not-for-profit trusts (Conservative Party, 2015). Legislation introduced last year to enable children’s social care services to be outsourced to independent providers also requires them to be not for profit (Department for Education, 2014b). Likewise, social housing changed significantly in the 1980s and 1990s with the development of a registered social landlord system whereby access to government-backed finance and other benefits required providers to be not for profit (a stipulation that has only recently been relaxed). In contrast, the majority of recent successful bids for establishing new probation service organisations were led by for-profit companies, despite some attempts by central government to help charities, social enterprises and staff-owned mutuals.<sup>vi</sup>

Another approach that could be explored to ensure the appropriate public accountability of new integrated providers would be to develop an adapted licensing, assurance or registration regime to recognise the values, expertise and governance required of organisations responsible for a whole population.

## 2. What does this mean for the future of transparency, regulation and inspection?

The experience of other sectors is that the **role of independent inspectorates and regulators in ensuring accountability may become relatively more important** for delivering public accountability and trust as providers take on more autonomous responsibilities for planning and managing services. In education, for example, the role of Ofsted has generally grown in importance as that of local authorities has declined. In employment services, the national provider assurance process (managed internally by the

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vi Although many of the successful bidders to the Transforming Rehabilitation Programme were partnerships that involve social sector organisations, it appears that around three quarters of the successful providers are led by private sector partners.

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Department for Work and Pensions) is an important element of ensuring value for money.

There exists significant debate about the level and quality of inspection and market oversight in the health and care sector. In my view, although this is the case, recent developments in the regulatory and inspection regime – such as the Care Quality Commission’s reintroduction of a quality grading system, plans to provide greater financial transparency on primary care and the testing of system-level inspections – are welcome as new models of care are established. They should be invested in further (Care Quality Commission, 2015).

As importantly, investing in good, smart systems to increase transparency across a wide variety of indicators of quality and outcomes is likely to be central to improving accountability in a system with more autonomous providers. In looking at how some of the world’s best public services operate, such as some of the Scandinavian health services or the education system in Ontario, Canada, I have been struck by how central agencies tend to place less emphasis on directing organisations, but greater emphasis on the collection and dissemination of good information on performance and best practice (see, for example, Cabinet Office, 2008).

Increased financial transparency, such as open book accounting, may also need to become a priority under a capitated payment model. The experience of other sectors with complicated supply chains, such as major infrastructure projects, is that while there are advantages in leaving providers to determine how they spend their money, it is still important for government funders to then quickly understand how that money is being spent if providers are to be held to account (National Audit Office, 2015). In particular, some parts of the NHS, such as community services, have traditionally been delivered under block contracts, where the relationships between funding, services and outcomes remain poorly understood.

The opportunity of integrated care, therefore, is to evolve the inspection regime and system of transparency to focus more on outcomes. Alongside this focus, those delivering these functions will need considerable skill and adaptability to offer valuable scrutiny and insight across a range of environments as providers take on

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more responsibilities and gain potentially dominant positions – while not stifling the very innovation that new models are seeking to catalyse.<sup>vii</sup>

### 3. How can commissioning become a more strategic function?

**CCGs may well need to evolve.** As the local provider landscape changes during this Parliament, it would be unwise to formally reorganise the structure and remit of CCGs. In the longer term, however, it is difficult to see how their membership, scope and size can stay constant if the reforms envisaged in the *Five Year Forward View* and Care Act are fully implemented. A more strategic function, potentially with a stronger sub-regional focus, would arguably be more attractive.

If integrated providers develop, CCGs' local roles would necessarily diminish. One Accountable Officer of a CCG recently speculated, for example, that their CCG may have an oversight role more akin to that “played by Police and Crime Commissioners ... [with] much of the demand management and service design functions transferred to the integrated care organisation” (Illman, 2015). If large, vertically integrated systems including specialist acute services become common, the value of oversight at a sub-regional level would also grow.

In my experience, the bringing together of some commissioning functions at a more strategic level could further be driven by the need to consolidate technical commissioning capacity. For example, for capitated contracts to be effective, there is a strong argument for introducing an element of payment-by-outcomes and partnership mechanisms for adapting the contract over the long term. Such contracts have benefits if well designed, but require significant capacity and skills to establish. This is one of the reasons why, as employment services contracts became larger and more based on employment outcomes, the Department for Work and Pensions decided to centralise procurement nationally. Even with support

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vii Concern over such ‘producer capture’ was one of the reasons for the introduction of the purchaser–provider split in health care in the first instance, and is always a risk in sectors where there are natural monopolies or consumers have little information.

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“Change may be needed because of the increasing difficulty of managing conflicts of interest between GPs as both members of CCGs and providers within integrated services.”

from large, specialist commissioning support organisations, it may be very challenging for CCGs in their present form to develop and manage such contracts on their own.

Finally, change may be needed because of the increasing difficulty of managing conflicts of interest between GPs as both members of CCGs and providers within integrated services. The recent move to manage the co-commissioning of primary care by CCGs has been accompanied by advice on how to avoid conflicts, such as co-opting members from the Health and Wellbeing Board (NHS England, 2014b). However, if the transformation and integration of primary care is going to be central to local strategies for improving overall care it is difficult to envisage how these elements of commissioning can be kept separate from other decisions. Some of the best GPs may also be more attracted to building larger provider practices than working in CCGs (Holder and others, 2015).

There are, however, a number of options for how commissioning could become a more strategic function.

### **Merging CCGs geographically to form sub-regional groupings or a single sub-regional body with an oversight over a wider health and care economy**

The proposed Greater Manchester approaches to joint commissioning, with more decisions taken at the city-region level, is potentially a useful pioneer in this regard. My understanding of the Greater Manchester model is that all parties (NHS England, the 10 local authorities and 12 CCGs) are planning to pool some of their responsibilities. The arrangement should make it easier to come to decisions on issues such as the number and locations of centres of specialist and acute care. Under the proposed Greater Manchester Health and Social Care Memorandum of Understanding, the details of joint decision-making are still being finalised, but will include a city-region Partnership Board and Joint Commissioning Board.

The Memorandum of Understanding promotes the principle of subsidiarity within Greater Manchester, with decisions being taken as locally as possible within the framework, and existing commissioners retaining their formal responsibilities. However, my view is that, in the long term, Greater Manchester may also develop

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“Perhaps the trick for CCGs should be to maintain their current structure, but to develop plans that would allow them to radically change their shape and position in the system.”

some budget of its own, managed by the city-region mayor, if the arrangement is to be permanent and meaningful. For example, this could be the body responsible for the Better Care Fund. A new Greater Manchester-wide funding stream, and similar arrangements in other city regions and potentially counties, may also help central government to find a way to channel much-needed additional funding into social care, without ministers becoming formally responsible for social care or having to significantly reorganise local government finance.

### Merging CCGs with Health and Wellbeing Boards

The Labour Party indicated that they would consider merging these two entities should they have formed the new government, and as noted previously, The King’s Fund recently considered the concept in work following up on the Independent Commission on the Future of Health and Social Care (Humphries and Wenzel, 2015). Such an approach provides an opportunity for strategic oversight of health services, care and the wider determinants of health and wellbeing such as leisure, housing and employment. It could, however, blur the line of accountability from NHS England to front-line health services.

Some combination of both of these options may be possible. For example, more of the significant, long-term integrated health contracts or ‘franchise concessions’ could be let and managed at sub-regional level, thereby freeing the local level to focus on health prevention, wellbeing, some elements of social care (e.g. care for those of working age with learning disabilities) and representing local needs within a sub-regional structure.

Perhaps the trick for CCGs should be to maintain their current structure, but to develop plans that would allow them to radically change their shape and position in the system, exploring scenarios in which their functions move to accountable providers or larger outcome-focused commissioners.

# What decisions need to be made regarding the voice of local representatives?

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Over the last few years, the coming together of health and care services, the transfer of public health responsibilities to local authorities and the development of Health and Wellbeing Boards have given local politicians a greater voice in health care. At a time when health is becoming an increasingly important challenge and the prevention and management of long-term conditions are so clearly linked to other local needs such as employment, housing and leisure, this is welcome. Accountability for the local health service remains opaque to many, and an effective role for local councillors in partnership with others has the scope to strengthen decision-making and improve access and responsiveness.

Yet it is not clear that local elected councillors will necessarily play a greater role in health and social care in five years' time unless they think creatively about their engagement now. Some of the other trends outlined in this paper run counter to the assumption that local councillors will have more power:

- an emerging national system of social care entitlements and lack of resources to do more than meet these statutory requirements
- the potential for an integrated NHS and social care budget
- the potential growing power of providers and mergers of CCGs to become more strategic health commissioners.

For local authority elected leaders, it is therefore important to develop additional ways to champion and oversee improvements to the health and care of their local population. Simply relying on their influence as funders of diminishing local social care budgets or by seeking more powers for Health and Wellbeing Boards feels insufficient.

- I believe that there is a case for **local authorities further consolidating their leadership of efforts to promote the wider wellbeing of their populations**, building on the transfer of public health and measures to improve wellbeing which many councils commenced long before that transfer. This could involve, for example, merging the non-personal care social care expenditure and elements of public health budgets (as Lancashire

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“It is not clear that local elected councillors will necessarily play a greater role on health and social care in five years’ time unless they think creatively about their engagement now.”

is starting to undertake with its Integrated Wellbeing Framework approach), and potentially many leisure services (such as in the Birmingham Be Active programme). It could include being bolder in using planning powers to better promote the health of the population and pioneering new models of housing for those with health and disabilities. It could see authorities using new responsibilities for economic growth and skills to take the lead in reversing the negative spiral of poor health and employment which has such a detrimental impact on people’s wellbeing and is responsible for an increasing proportion of welfare expenditure on those of working age – as Greater Manchester authorities are already pioneering.

- **Strengthening local and national democratic scrutiny** will be even more important if integrated care develops as planned. Health and Wellbeing Boards currently have rather a hybrid function of part scrutiny, part co-ordination and planning. Local authority scrutiny committees have a role, but are generally not well resourced. The opportunity may be to build a much better resourced local or regional scrutiny function, potentially with joint groups of councillors and MPs holding new local providers more directly to account with the support of expert advisers.
- Local authorities could also explore becoming **stakeholders in new providers**, whether seeking rights to nominate some board members as part of the integration of social care funding, or potentially taking ownership stakes in emerging primary care organisations. There are pros and cons of such executive engagement compared with a well-resourced scrutiny function – for example, some municipal authorities in Germany and elsewhere have shifted away from the ownership of hospitals as financial challenges mount and investment in services and infrastructure is required. However, if managed effectively and not too great a financial strain, partial ownership or nomination rights could strengthen the voice of local representatives.

Finally, I believe that there are some difficult choices that local councillors need to make over whether they should seek to hold on to as much direct responsibility as possible for funding packages of social care for those with substantial and critical needs (particularly for older people), consolidate these into city-regional structures

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“It would be helpful for areas such as Greater Manchester and the Leeds city region to undertake a detailed analysis of the pros and cons of different social care package options.”

such as the potential Greater Manchester devolution deal or pass assessment and resource allocation responsibilities to integrated providers.

In making these choices, local leaders will need to consider the best approach for recipients of care and for addressing the financial challenges they face. There is clearly value in local oversight of and accountability for care: some participants at a seminar the Nuffield Trust held to consider these issues argued that the public often has a much greater sense of their council being responsible for social care than who is responsible for the local NHS. There are important local interdependencies between packages of social care, wider wellbeing and prevention services, housing and (for younger adults) children’s services. Yet with the Care Act introducing greater standardisation, significant constraints on local revenue sources and potential advantages in commissioning vertically integrated care providers at a sub-regional level, the careful delegation or transfer of responsibility for some social care funding also has attractions. Rather than just ‘muddling through’, it would be helpful for areas such as Greater Manchester and the Leeds city region to undertake a detailed analysis of the pros and cons of different options and to support other local authorities to take a proactive approach to the funding of social care packages.

# Conclusion

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Developing better public accountability systems may seem peripheral to the urgent task of transforming care and delivering savings. The various rounds of structural reform to commissioning organisations over the last two decades, from health authorities, to primary care trusts, to clinical commissioning groups, also demonstrate how distracting changes in governance can be. Arguably, the NHS is only just getting used to the last set of reforms. Add in the significant political difficulties associated with formally altering the governance structures of the NHS and it is easy to see why many leaders in the health and social care sector may not wish to engage in such issues now.

Yet ignoring accountability would be a mistake in my view.

The first reason for taking accountability seriously is that without clear, transparent, effective and trusted governance and scrutiny, good ideas often fail in their execution. For example, the worthy attempt by the last Labour Government to join up children's services in part failed to have as much impact as anticipated because the governance mechanism – Children's Trusts – never delivered a clear enough line of accountability (see Department for Children, Schools and Families, 2008). Individual Learning Accounts, another appealing idea to give young people more control over their training and education in the late 1990s, were wound up because insufficient thought was given at the start regarding how best to identify and address fraud and poor value for money (National Audit Office, 2002).

The second reason for giving accountability careful consideration is that when new public service delivery organisations take shape, their organisational form can endure for a long time. For example, the nature of general practice ownership recognised at the birth of the NHS in 1948 has remained remarkably stable. The precedents which are set now as the health and care system evolves may be more significant than their originators imagine.

This does not mean that political leaders and those working in health and social care need to quickly settle on a new set of national accountability arrangements. There is enormous value

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in exploring and refining the care system that is needed and then supporting that with appropriate systems of governance, scrutiny and redress. Nevertheless, it is important that leaders anticipate the issues and choices that are likely to arise if the current division of responsibilities between the purchasers and providers of services are redrawn and the funding of health and social care becomes ever more intertwined.

As highlighted in the previous sections, I think that the most significant issues will be:

- **The need to build appropriate governance arrangements into the new integrated provider models that are emerging, particularly models which grow out of primary care.** From an organisational perspective, these new arrangements need to be simple, transparent and robust. I would also argue that mechanisms are required to ensure that the aspirations and needs of the population served are reflected in the decision-making processes of these new integrated providers. It will be important to assess whether the reforms to governance introduced following the Francis Reports are sufficient to deliver this, or whether the new responsibilities of integrated providers need to be accompanied by additional requirements around ownership, purpose and assurance.
- **The likely need for more strategic commissioning, and associated responsibilities of regulators and inspectors.** While there will always need to be a separation between those authorising public expenditure and those managing it, the potential devolution of service planning to providers raises a range of questions about CCGs in the long term. Should they just keep a limited range of local functions or should sub-regional commissioning grow? If so, can it arise by voluntary agreements between existing local commissioners or will more formal structures be required over time? Beyond these structural questions, the nature of the funding agreements will be important. For example, integrated providers could be given potentially permanent responsibilities, in a similar way to school academy trusts having an ongoing funding arrangement, or fixed-term franchises. They could be paid purely on a capitated basis, or partly on the basis of outcomes. I believe that independent inspection and regulation will always be important in health and

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“When new public service delivery organisations take shape, their organisational form can endure for a long time.”

care, but its nature will be partly driven by capacity of strategic commissioners and availability of transparent information on outcomes and quality. There is important learning to draw upon in regard to all these issues from other public services and around the world.

- Finally, **leaders will need to find better ways to give people a meaningful voice in decisions over their integrated local services**, within a national (or regional) framework. The challenge for local political representatives is not simply to seek stronger powers *per se*, but to build their role by taking a greater lead in developing better ways to support people’s health and wellbeing, through their public health functions, housing, leisure and planning responsibilities, as some councils are already achieving.

The absence of a major piece of legislation offers the chance to consider these issues carefully over time, but it should not be used as an excuse for inaction. Otherwise we may end up with a future system that is less accountable, and less effective, than at present.

**Ben Jupp, July 2015**

*Written in a personal capacity to stimulate discussion. The views in this paper do not necessarily represent those of the Nuffield Trust or Ben’s employer, Social Finance.*

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# Expert responses to Ben Jupp's Viewpoint

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# The view from Healthwatch: Jan Sensier

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Jan Sensier is Chief Executive of Engaging Communities Staffordshire, a not-for-profit public interest company delivering Healthwatch by tracking public and patient experiences of health and social care services in the county.

It is perhaps apt that a local Healthwatch response to Ben Jupp's thought-provoking paper should come from Staffordshire. The public here are still living with the consequences of the historic Mid Staffordshire NHS Foundation Trust Public Inquiry mentioned in the report, and some of the problems it uncovered can be linked to governance issues around the Trust board's push towards foundation status.

Staffordshire is also a good test case for the other trends Ben identifies. We are a financially challenged health economy; we experienced the worst A&E performance this winter; and we have a multiplicity of CCGs all striving to bring forward new approaches to commissioning. The cancer/end-of-life programme in the north and the 'Improving Lives' programme in the east both embrace the service integrator model. And from the viewpoint of a local Healthwatch dealing with these issues, there does indeed seem to be an ever-increasing blurring of the lines of the commissioner-provider split, just as Ben predicts.

Maybe that is timely. Too rigid an adherence to the model can result in decision-making being divorced from the frontline, and can lead to duplication. For example, public consultation has to be carried out by both the lead Trust making changes, and by the commissioners. There is also evidence of duplication in public and patient involvement – patient participation groups, NHS Citizen, Trust governors and patient engagement groups and Healthwatch itself. We are not yet skilled at drawing these resources together to enable a strong patient voice holding the system to account.

From a public perspective, the NHS is still seen as one organisation, and many are unaware of the myriad businesses that actually constitute today's health service. This is really made clear when we deal with patient complaints – most do not know where to complain due to the complexity of the system. Ben foresees a world of more strategic commissioning and more integrated provision. We should ask whether that might also unlock efficiencies in terms of accountants, contract management, business development officers and so on.

Social care poses a real and present challenge. While integration may not yet be proven as the 'magic bullet', we see evidence that

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social care cuts can lead to more costs and pressures in health care. The role of the local authority is therefore key. While it will be interesting to see the impact of Devo Manc, from a Healthwatch standpoint there seems to be clear logic in strengthening the role of Health and Wellbeing Boards as strategic commissioners. As well as bringing democracy to the table, these bodies have the independent voice of the public through Healthwatch, thereby strengthening accountability. They also bring in public health, controlled by local authorities and vital if we are to truly tackle prevention and early intervention.

However, strategic commissioning will need to be backed up by strong standards across all services – not just the headline-makers like A&E and hospital mortality. We have recently been reminded of this in Staffordshire through the work of one patient campaigner on orthotics (the splints, braces and devices that support muscles and bones to promote rehabilitation). It could be seen as a Cinderella service, but, if done badly, risks more suffering and much greater expenditure down the line. Without detailed commissioning specifications, service standards will be the main tool for continuing the drive towards excellence.

In summary, Ben's article echoes many of the thoughts and feelings we pick up around the system: no appetite for organisational change, but a recognition that things are not currently fit for purpose and that the world is moving on. Just don't forget the most important factor for real accountability: the voice of the public and patient is vital for great services.

# The view from Westminster: Stephen Dorrell

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Stephen Dorrell is a British conservative politician. He was Secretary of State for Health from 1995 to 1997 and served as an MP for over 25 years, recently standing down as MP for Charnwood and Chair of the Health Select Committee.

The Government's promise to avoid further large-scale reorganisation of NHS structures has been widely welcomed, but ministers will soon need to clarify exactly what this means, and what it does not mean.

It cannot mean a period of stasis.

Every ministerial speech which offers reassurance that there is going to be no blockbuster attempt at 'NHS Reform' includes another passage which rightly stresses the need to develop more joined-up health and care services. They argue that, instead of rationing access to health care services in cases where avoidable acute need has arisen, we need to develop more supportive services that allow us to enjoy lives which are healthier as well as longer.

This will require a process of sustained evolution. Services that were developed to meet different needs in a pre-digital age will need to be re-imagined so that they meet tomorrow's needs, using tomorrow's technology.

The question is: who is going to make sure that happens?

All too often, discussions about accountability focus on structures and processes, emphasising the importance of reconciling different interests. All of that is important, but it is in danger of confusing method with purpose. Accountability structures don't exist to justify the status quo – they exist to facilitate change.

Measured against that test, Ben is right to question whether current commissioning structures are fit for purpose.

Are they able to look across the statutory silos which divide hospitals from general practice, mental health from physical, and the NHS from other services people rely on? Can they test outcomes achieved in one area against those achieved in similar communities elsewhere in the world? Are they able to coordinate resources effectively to create services which reflect the needs of citizens? The questions are almost rhetorical. Through no fault of those who work in them, they cannot.

The integrated care structures proposed by the *Five Year Forward View* certainly help. The Vanguard sites all aim to demonstrate how Multispecialty Community Providers and Primary and Acute Care Systems can use resources more effectively and improve service integration within the NHS.

But these evolving provider structures do not answer the accountability questions; indeed, in some ways they make them more urgent as they create larger NHS organisations which will be dominant providers of health care with the attendant risk that they become absorbed by an internal agenda which may not reflect the broader views and interests of their local communities.

From the citizen's perspective it isn't merely that NHS services need to be better integrated; there is also a requirement for their effectiveness to be regularly tested and for the services provided by the NHS and other agencies (most obviously, but not only, social care) to be better coordinated.

NHS England cannot allow itself to default to becoming 'Head Office' for a group of health care providers; it exists to work with local commissioners to ensure that providers are held to account. This is why the key relationship for NHS England must be with local government – and vice versa.

Neither side can do its job without close engagement with the other. There can be no meaningful concept of local government which does not have the principle of equitable access to high-quality public services at its heart. Similarly, the modern NHS needs to re-engage with local communities in order to ensure that its services reflect the considered priorities of those communities.

There is widespread consensus about the requirement for health and care services to evolve towards a more integrated model. Ben Jupp's paper represents an opening salvo in a necessary parallel debate about the shape of commissioning required to facilitate these fundamental changes. As the pace of change is quickening all the time, someone must speak for the public to insist that providers keep up.

# The view from commissioners: Dr Steve Kell OBE

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Dr Steve Kell OBE is Co-Chair of NHS Clinical Commissioners, Chair of NHS Bassetlaw CCG, and a general practitioner.

It is tempting to focus on structures and organisations when discussing the NHS and the health outcomes of local people. Politicians have proposed measures such as changing responsibilities or the mandatory pooling of budgets to improve health. But I would argue that we already have the structures in place to deliver improvements to population health. We should focus first on improving health outcomes for our patients, and allow the system to evolve – not get distracted by structural reorganisations.

CCGs were created with one simple idea: to harness the expertise and local knowledge that front-line GPs and clinicians could bring to commissioning. Clinically led commissioning is a strategic function. It uses the insights of clinical professionals, with our face-to-face relationship to patients, to help understand the health and wellbeing of local populations, and map out their needs for the long term. It is also capable of delivering on financial expectations in a highly challenging fiscal environment.

Concerns that conflicts of interest between GPs as commissioners and GPs as providers of care would hinder decision making have so far proved unfounded. CCGs and their governing bodies are recognising where conflicts of interest might arise and are managing them, rather than seeing them as a barrier to commissioning high-quality care in a local context.

Clinical commissioning is already delivering for patients. It continues to evolve and mature into a system that is focused on patient wellbeing as well as illness and is making a positive difference.

The recent responsibilities CCGs have taken on to commission primary care give us the opportunity to start to genuinely join up care and address some of the fragmentation in local health economies. It will also offer those involved in delivering front-line primary care the chance to become actively engaged in the commissioning process.

Health and Wellbeing Boards provide a key opportunity for joint working between organisations that have worked independently for too long. CCGs are embracing this opportunity to work at a place

level alongside council colleagues to address the social, economic and health care factors that create a healthy population.

We recognise there is an urgent need to enable commissioners to achieve much more, at scale and pace. This means giving CCGs the freedoms, flexibilities and resources to make the bold, big decisions that the NHS so desperately needs.

The Vanguard process, through which NHS England is piloting the more integrated providers Ben Jupp discusses, has shown that CCGs are at the fore of developing new models of care. We are not afraid of taking bold decisions to radically change the way care is delivered to our patients. These new models will see CCGs evolve in different ways, but what is certain is the need for a strong commissioner voice which can hold these newly developing organisations to account at a local level.

Integrating health and care is critical to a safe and sustainable health service. CCGs are uniquely placed to use their clinical expertise, their roots in the community and their system leadership role to work in partnership across the health and care system to do just that and make a difference for their patients. Without clinical commissioning to harness this powerful combination, it couldn't happen.

# The view from local government: Councillor Izzi Seccombe

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Cllr Izzi Seccombe is the Leader of Warwickshire County Council. She has overall responsibility for corporate policies and planning, performance and strategic issues, communications, budget, economic development, skills and external relations, including the Health & Wellbeing Board and Local Enterprise Partnership.

There is cross-party consensus both within the Local Government Association and nationally that integration of health and social care is the right approach, particularly for improving outcomes for citizens, but also for improving value for money in the long term.

Jeremy Hunt is clear that a strong NHS depends on a strong social care system, and vice versa. I couldn't agree more. But recognition of mutual dependencies, while helpful, will not alone guarantee the kind of progress we need. What will? There are as many answers as there are conversations on the ground.

As a localist I believe that is absolutely as it should be. Anyone in the sector will tell you that the primary objective of integration is improving outcomes for individuals by building a joined-up system around them. But you'll get a multitude of answers on how you achieve that, reflecting the particular subtleties of a particular patch.

Of course, progress with integration inevitably also plays out within the wider context for health and social care. The enormous pressure on budgets is perhaps the most inescapable issue, and dealing with this over the last four years has been extremely challenging for all councils. Spending on adult social care has been kept under control through savings worth a staggering £3.5 billion (with a further £1.1 billion planned this year), and a cross-subsidy from other council service savings of at least £900 million in 2013/14 in addition to the transfer of NHS resources to social care.

For 2015/16 that £1.1 billion transfer is part of the Better Care Fund (BCF), a joint budget across the NHS and councils with the potential to transform the way care is commissioned, designed and delivered. It is an important acknowledgement of NHS reliance on social care – evident from last winter's A&E crisis, when councils worked around the clock seven days a week to support hospital discharge teams and alleviate NHS pressures.

But look deeper and there's a fundamental imbalance. The BCF has become heavily NHS-focused and bureaucratised with no discernible change as a result. And on winter pressures while 25 per cent of delays leaving hospital are attributable to social care, funding is skewed massively in favour of the NHS. This reflects

a wider inequality. On the one hand NHS Trusts are reporting deficits of more than £820 million and funding for health has been protected. On the other hand social care has had to make its share of major savings to return balanced budgets every year.

So what price integration for local government? Councils have a strong track record on partnership working and are fully signed up to the BCF. But, realistically, transformation is neither desirable nor possible if the foundations of the system cannot be sustained. Social care needs to be placed on a firmer financial footing if it is to play its part in joining up services.

If we can sort the money out, then there should be scope to increase the ambition and scale of the BCF, with a much greater focus on prevention. But one final piece of the puzzle still requires a bit of shaping before it slots into place: governance and accountability. This is about ensuring local governance of health and care is rooted in our local communities. The most obvious way to do this is by maximising the leadership potential of Health and Wellbeing Boards (HWBs) so they can drive local approaches to improving people's outcomes that reflect unique local needs and other local services.

They have made a good start – joining up strategic commissioning, taking preventative approaches, and bringing all the right people to the table – but they can and should go further. That's a challenge for all partners, but especially for councils and clinical commissioning groups. Local leaders need to ensure that HWBs feel as much a decision-making body of the clinical commissioning group as of the council. They need to establish the right size of area to cover and support all partners sharing the same information. Government should give HWBs the freedom to set their own local priorities and support this by establishing five-year funding settlements across health and care. Inspection, regulation and reporting should be integrated and proportionate as well.

This list is by no means exhaustive. There is much more to be done. But we are starting from a promising position and there is an unquestionable appetite for the work required to realise the benefits of integration. Now the Government must show its hand in how it intends to help make this happen.

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59 New Cavendish Street  
London W1G 7LP  
Telephone: 020 7631 8450  
Facsimile: 020 7631 8451  
Email: [info@nuffieldtrust.org.uk](mailto:info@nuffieldtrust.org.uk)

 [www.nuffieldtrust.org.uk](http://www.nuffieldtrust.org.uk)

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