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Effective commissioning for integrated service delivery at Place: what functions and structures does the literature suggest are required?

Literature Report

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Introduction

The vision of the NHS set out in the Long Term Plan and subsequent legislation (Health and Care Act 2022) and guidance is of a system built upon collaboration and co-operation, with competition between providers replaced with collaborative development and delivery of services which are more integrated across sectors, organisations and scales (Department of Health, 2021; NHS England, 2019; NHS England, 2019a). The vehicle for implementing this vision was the creation of 42 Integrated Care Systems, bringing together providers and commissioners and giving them a statutory duty to plan and deliver services for their geographical population. Guidance suggests that within these large systems, responsibility for the planning and delivery of community-based integrated services will, in adhering to the principle of subsidiarity, be delegated to geographical Places (NHS England, 2019a). The exact boundaries of these are left to Systems to determine, but it is suggested that they should be designed to support co-operation between primary, community, mental health, social care and voluntary sector service providers, and should align reasonably well with Local Authority boundaries.

Whilst the relevant policy documents emphasise the importance of collaboration and joint working, it is important to highlight the fact that the Act did not fundamentally alter the underlying logic governing the operation of the NHS since 1991. Prior to 1991, services were planned and managed by Health Authorities, which were responsible for providing care to defined geographical populations. The size of geographies delineated in policy varied over time (Lorne et al., 2019), but the underlying logic remained one of Health Authorities having managerial responsibility for ensuring the delivery of services to their population (Sheaff et al., 2015). Following the 1989 White Paper, Working for Patients (Department of Health, 1989), a fundamental change was enacted, by which responsibility for 'purchasing' and 'providing' healthcare services were separated from one another – the so-called 'purchaser-provider split'(Harrison, 1991). NHS Providers were encouraged to become self-governing Trusts, and Health Authorities were given responsibility for orchestrating rather than providing services for their population (Flynn & Williams, 1997a). The crucial mechanism underlying the quasi-market was that of contracting – Health Authorities negotiated and monitored contracts on behalf of their population (Allen, 2002). Whilst the initial impetus for this change included a desire to increase competition between providers, the resulting 'quasi-market' was only partially competitive – most contracts remained with local NHS providers (Exworthy et al., 1999; Mays et al., 2000). Since 1991, the emphasis placed upon the desirability of competition within the NHS has varied. The New Labour government in 1997 replaced Health Authorities with Primary Care Trusts (Secretary of State for Health, 1997), with the language shifting from 'purchasing' care to the more general language of 'commissioning', in keeping with the language used in other public services (Glasby, 2012). However, despite a rhetorical commitment to reducing competition, in practice the New Labour government continued the quasi-market, with a particular focus on allowing patients a choice of provider (Department of Health, 2003, 2011; Greener, 2009). The Lansley reforms of 2012 saw a return to competition as an animating principle in the NHS, with the Health and Social Care Act 2012 applying European competition law to the NHS (Osipovič et al., 2020), but despite changes in regulations, the extent to which services were actually competitively procured remained limited (OsipoviČ et al., 2016).

It is against this backdrop that the 2022 Health and Care Act signalled a shift to greater collaboration and co-operation, although the fundamental architecture of service provision established in 1991 – that of services governed by contracts between a provider and a commissioner (or purchaser) - was left intact. Legally, Integrated Care Boards were invested with the responsibility for ensuring the provision of services for their geographical populations which had previously sat with Clinical Commissioning Groups, and the underlying mechanisms by which services are paid for (a mix of block contracts and activity-based payments) were not fundamentally changed. Importantly, NHS providers remain independent self-governing Trusts which are monitored and regulated as sovereign organisations. Thus, post-Health and Care Act 2022, the duty to collaborate vested in Integrated Care Systems sits within an underlying architecture which requires the negotiation and monitoring of contracts for the provision of services (Sanderson & Allen, 2021).

In this context, the mechanism by which services are planned, established and monitored in their delivery to meet local needs remains that of 'commissioning'. Often envisaged as a 'cycle', commissioning involves the systematic assessment of local needs, the design of services to meet those needs, the development of appropriate finance and monitoring mechanisms, the assessment of how far services are delivering what is required and the adjustment of services as needs and other factors change (Allen et al., 2020; Glasby, 2012). Whilst this method can be used to support a competitive approach to service procurement (with rival providers competing for contracts to deliver specified services), commissioning does not require competition between providers; the basic activities of commissioning are also applicable to any complex service delivery system where services are delivered according to a contract. Even in the absence of competition, providers must still be monitored to ensure that service quality and coverage meet identified needs, and in any system operating within a fixed operating budget, mechanisms must be in place to decide priorities, adjust funding allocations and monitor financial performance. Furthermore, in a system intended to foster collaboration and joint working, whilst providers, as experts, will necessarily be involved with service design decisions, mechanisms must be in place to broker relationships between providers, adjudicate when disagreements occur and to uphold and represent the interests of service recipients, which will not necessarily always coincide with the interests of the different providers (Allen, 2002, 2013). Thus, even in the more collaborative system envisaged in guidance and formalised in the Health and Care Act 2022, the activities of commissioning will still be necessary in some shape or form, and some sort of co-ordinating and overseeing authority is required (Lorne et al., 2019; Sanderson et al., 2020).

In this report we consider the research evidence on the activities required to effectively commission services for geographically defined populations and bring this together with the international literature on the factors necessary to support the delivery of integrated services. The resulting framework will be used to guide our empirical work in order to provide policy-relevant evidence as to what Integrated Care Boards need to do to establish effective integrated service provision within Places.

The activities of commissioning: what does the evidence tell us?

The concept of commissioning has been said to derive from Ovretvreit's purchasing framework (Øvretveit, 1993), which sets out the cyclical process of strategic planning for services including a systematic approach to needs assessment, service planning, contracting, monitoring and review. Notwithstanding critiques of the so-called 'strategic purchasing'

approach (Greer et al., 2020), the resulting 'commissioning cycle' has formed the basis underlying service development in the NHS in England for many years (Department of Health, 2007).

Early evidence highlighted the resistance within the NHS to a transactional, contract-based approach to service development, with those involved emphasising the important of relationships and trust (Dopson & Locock, 2002; Flynn & Williams, 1997b). The history of the NHS since 1997 has been one of restless reorganisation, as successive governments have sought to optimise the structures within which services are planned and delivered in order to realise the presumed benefits of the purchaser-provider spilt (Klein, 2013). The authority responsible for commissioning was successively changed from Health Authorities to Primary Care Trusts and then to Clinical commissioning Groups. Each change modified the exact scope of services covered as well as modifying the administrative arrangements within commissioning authorities. However, the basic task – that of ensuring services were available for defined populations – remained the same during each reorganisation.

In the wake of the New Labour reforms of the early 2000s, Wade et al (2006) undertook a large-scale study of the activities of and requirements for a commissioning authority. Focused upon the demands upon newly established Primary Care Trusts, the team reviewed the literature and undertook primary research exploring what functions were necessary for the effective delivery of commissioning. Whilst the broader NHS context has changed several times since then, as discussed above the fundamental underlying logic of the system remains the same, with services delivered according to contracts between providers and commissioners to meet needs and strategic objectives identified by the relevant commissioning authorities. Their analysis therefore provides a useful overview of the commissioning activities which evidence suggests are needed. The study highlighted:

- *Objective setting and decision making*, including: appropriate balance between national/regional and local objectives; mechanisms for setting those local objectives; clarity over the scope of decision-making powers vested in the commissioning authority; and governance structures by which they can be held to account for those decisions
- *Management of partnerships* across their geographical footprint, with recognition by partners of their legitimacy to do this
- *Supporting patient choice*, with this seen as the mechanism by which the public can influence the care that they receive
- *Information collection and analysis*, including: population health needs; local service maps; provider activity and quality data; patient satisfaction data; and intelligence about potential future factors likely to affect demand. Commissioners also need the analytic capability to understand trends and make sense of what the data is showing.
- *Service design and resource allocation*. Within this category the authors highlight the need for commissioners to work closely with providers in service design decisions, and also the potential for some more specialised services to be designed and delivered over larger footprints by consortia of commissioners.
- *Procurement and contracting*, including: service specifications; contracting procedures (including competitive processes where relevant); contract monitoring; quality improvement; and performance management.

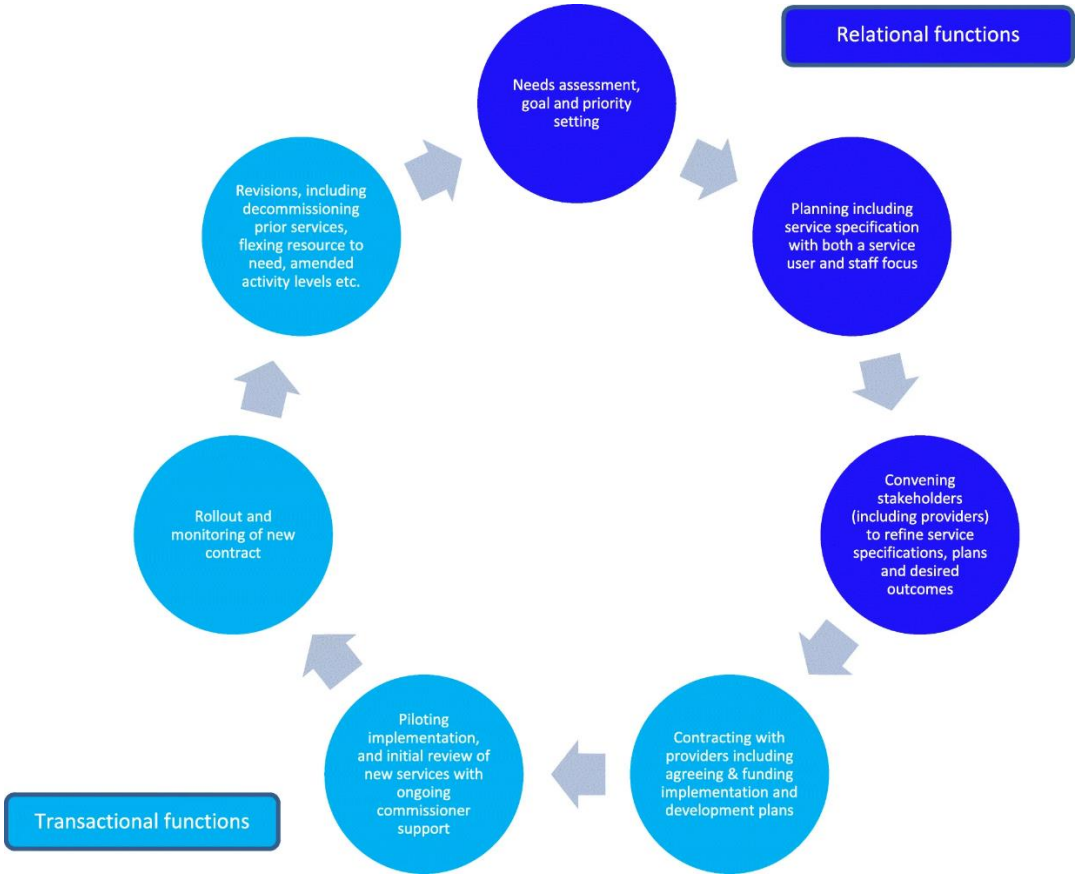
The report goes on to highlight the importance of clarity around objectives, decision making power and perceived legitimacy within the local health economy, as well as appropriate supra-commissioner structures within which commissioners can be held to account for their conduct

of their role. Accountability to the public is also highlighted, with a focus upon the so-called 'principle-agent' problem (Baxter et al., 2008), by which commissioners are agents charged with delivering services for their population, but mechanisms by which the population can hold their agent (the commissioner) to account are lacking. Underpinning all of this is the need for skilled managers, who understand their local health economy, to build and maintain relationships, have access to appropriate clinical advice, communicate effectively with the public, and understand the wider system (Checkland et al., 2012).

Subsequent research in the NHS across various iterations of commissioning structures has drawn attention to a number of issues. Whilst contracts remain an important mechanism by which service provision is governed, research has highlighted the fact that contracting in the NHS is as much relational as it is transactional, with few examples of commissioners using formal contract mechanisms alone to govern providers (Allen, 2002). Furthermore, even during those periods where competition has formally been the basis on which commissioning is supposed to operate, the use of competitive contracting has been limited (OsipoviČ et al., 2016). Research has also highlighted the intensity of work required to achieve service redesign, with associated questions as to where the boundary should lie between work done by commissioners and that done by providers (Shaw et al., 2013). The role of patient choice in driving improvement has been questioned (Peckham, 2011), and the extent to which commissioners actually have the legitimacy to hold providers to account has been unclear (Dopson & Locock, 2002). National programme such as World Class Commissioning (McCafferty et al., 2012) sought to strengthen both the technical skills within commissioning organisations and perceptions of the role of the commissioner, with one of the core measures of commissioner success being the extent to which they were seen to be a leader in the local health economy (Department of Health, 2009).

Smith et al (2019) drew together research on commissioning to create an adapted commissioning cycle framework, (figure 1) which highlights the importance of convening relevant stakeholders and ensuring that service specifications take account of both staff and service user perspectives, alongside the more transactional functions such as contract monitoring and rollout.

Figure 1 adapted Commissioning Cycle taken from (Smith et al., 2019)



More generally, questions have been raised as to the value of separating the purchasing of healthcare from its provision and therefore the need for and utility of a commissioning approach. Klasa et al (2018) compared European health systems. Looking across a wide variety of international literature they developed a composite definition of 'strategic purchasing' which they argue encompasses the NHS definition of 'commissioning':

> *An evidence-based process that sculpts health care systems by prioritizing the financing of certain goods and services over others through collaborative planning across various healthcare stakeholders while incorporating the needs and priorities of citizens in the distribution of health care and promoting equity, quality of care, efficiency, and responsiveness in the provision of health services. (Klasa et al., 2018)*

Looking across 10 European countries they argue that, despite strong rhetorical commitments to the concept, none of the countries which they examined (including England) were able to fully implement a strategic purchasing approach, concluding that:

> *There are myriad reasons why this is hard. In practice, purchasers, even with great purchasing latitude, often lack the data, expertise, available network, policy capacity and negotiating power to shape an effective purchasing strategy that is focused on the quality of care and the actual needs of the population, instead of historical utilization patterns, prices and volumes. (Klasa et al., 2018)*

Greer et al (2020) draw attention to these market, financial, information and political asymmetries between purchasers and providers which affect the activities associated with the idealised 'commissioning cycle' presented above, making strategic purchasing difficult to achieve in practice.

Nevertheless, decisions must be made within health systems as to where money should be directed and what sort of care should be provided, by whom. Even where systems eschew competition between providers (such as Scotland and Wales (Greer, 2016)), it remains necessary for some kind of planning authority (eg Health Boards in Scotland) to assess local health needs, allocate money to different sectors and different providers and instigate a process for monitoring both quality and appropriateness of service provision. Indeed, whilst Scotland has rhetorically abandoned the 'purchaser-provider split', services are still provided according to (block) contracts, and a planning authority is responsible for both assessing local health needs and ensuring that services provided by contracted providers both match local needs and are of sufficient quality. Thus, despite the associated difficulties highlighted in the international literature, the 'commissioning cycle' remains a useful heuristic as it highlights the activities required to effectively plan services.

The delivery of integrated services

What is meant by the terms 'integrated care' and 'integration' is not always clear. Kodner and Spreeuwenberg (2002), argue that: *'integrated care as a concept is an imprecise hodgepodge. Its meanings are as diverse as the numerous actors involved'*, whilst Armitage et al (2009) suggest that there are more than 175 overlapping definitions and concepts linked with the term. The various documents upon which the legislative changes brought about through the Health and Care Act 2022 are based (NHS England, 2019a, 2019b, 2020) do not explicitly define integrated care. The NHS Long Term Plan (NHS England, 2019b p12) references: '*more joined-up and coordinated … care*' and '*breaking down traditional barriers between care institutions, teams and funding streams*', suggesting both service and financial integration, whilst an initial design document highlights the need to: '*join up planning and service delivery across historical divides: primary and specialist care, physical and mental health, health and social care'* (NHS England, 2019a p1). Geographical Places are highlighted as an important level with the newly designed system at which '*implementation of integrated care models*' (ibid p3) will take place, and it is therefore Place level upon which our research will focus.

The Darzi report on the current problems affecting the NHS (https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england) draws a distinction between collaboration and integration, arguing that: '*Collaboration and integration are often conflated, but they are not the same. Service or clinical integration is about a fundamental change in the way health services are organised for patients rather than the degree to which NHS organisations cooperate with one another as institutions.' (p77).* However, this does not address the fact that, however services within the NHS are organised, the delivery of service or clinical integration will necessarily require collaboration between different parts of the system, as the NHS is too big to be managed as a single monolith. Effective co-operation between organisational units (however these are constituted) is therefore the underlying condition required if care is to be experienced as integrated. A review of repeated integration initiatives in the NHS (R.Q. Lewis et al., 2021) highlighted the essential ambiguity at the heart of many 'integration' initiatives, with little clarity over what exactly was being integrated. The review concluded that efforts to improve

the integration experienced by patients should focus upon how best care could be co-ordinated across organisational, professional and geographical boundaries, wherever these boundaries fall and however services are organised, and it is this conceptualisation of integration that we focus upon here.

In order to explore the factors which enable and support the delivery of such co-ordinated care, we turned to national and international literature evaluating a mix of large and smaller scale integration initiatives. The choice of documents was pragmatic, focusing upon systematic reviews and summary articles addressing those initiatives which most closely resembled the type of integration and scale of initiative set out in the documents referenced above. There was thus a focus on initiatives attempting to integrate care and integrated working across sector boundaries and within particular geographies, as well as those which involved collaboration between a variety of different organisations.

Table 1: Collected publications relating to integrated care and integrated working relating to health and care services subject to analysis

Author	Date	Country	Title
Baxter et al	2018	UK & International	The effects of integrated care: A systematic review of UK and international evidence
Bhat et al	2022	UK	Identifying and understanding the factors that influence the functioning of integrated care in the NHS: A Systematic Literature Review
Cameron et al	2014	UK	Factors that promote and hinder joint and integrated working between health and social care services: a review of research literature
Erens et al	2015	UK	Early evaluation of the Integrated Care and Support Pioneers Programme - Final Report
Goodwin & Smith	2011	UK	The Evidence Base for Integrated Care
Gray et al	2020	Canda, New Zealand, Netherlands	Comparing International Models of Integrated Care: How Can We Learn Across Borders
Kelly et al	2020	UK & International	Measures for the integration of health and social care services for long-term health conditions: A systematic review of reviews
Kirst et al	2017	UK & International	What works in implementation of integrated care programs for older adults with complex needs? A realist review
Leitjen et al	2018	UK & International	The SELFIE framework for integrated care for multi-morbidity: Development and description
Lewis et al	2021	UK	Integrated Care in England - what can we learn from a decade of national pilot programmes
Miller et al	2021	UK	Integrated Health and Social Care Ten Years On

Neiva et al	2023	Brazil	How is Integration Defined and Measured, and what Factors Drive Success in Brazil? An Integrative Review
Piquer-Martinez et al	2024	UK & International	Theories, models and frameworks for health systems integration. A Scoping Review
Round et al	2018	UK	An integrated care programme in London: qualitative evaluation
Thomson & Chatterjee	2024	UK	Barriers and enablers of integrated care in the UK: A rapid evidence review of review articles and grey literature 2018–2022

The papers formally included are set out in table 1 above, but it is important to note that the themes which we developed following our analysis were also tested against a wider body of literature relating to integrated care. This confirmed that the same enabling and supportive components of an integrated care/programme recur consistently throughout the literature. In the rest of this section we briefly summarise the results of a thematic analysis across the papers included.

Strong leadership & management

Effective leadership and management were identified in all the papers examined. The importance of strong, engaged leadership was considered to play a central role in fostering many of the softer, behavioural enablers seen as pivotal to the success of integration aims, and in setting an organisational culture that builds trust and promotes team collaboration (Kirst et al., 2017). For example, Goodwin and Smith (2011) in a presentation on their report to the DH on a national strategy for integrated care, outline the role of leaders in clearly communicating core values and purpose, fostering a shared vision, common goals, good relationships, engaging professionals and building commitment. Lewis et al (2021) concur, suggesting that trust between senior leaders in different organisations is important, and that integration initiatives require leaders to be able to clearly articulate their vision and communicate this to front line staff. Bhat et al (2022) systematically reviewed evaluations of integrated care initiatives in the NHS and highlighted the importance of strong leadership from senior leaders, including the establishment of clear goals and a willingness to move beyond a single organisational focus to embrace a notion of the collective good. They go as far as to say that, *'leadership was deemed to be the most influential factor due to its intrinsic and instrumental role in influencing the other key factors'*.

However, reviewing reports of initiatives to promote integration between health and social care, Cameron et al (2014) suggest that establishing shared goals may not be straightforward, with a need for appropriate mechanisms to facilitate agreement as well as clarity over how far senior managers involved in initiatives can make decisions and commitments on behalf of their organisations via clear terms of reference.

Importance of good relationships

Developing trust and shared goals/vision are however, also dependent upon good working relationships between professionals and organisations. In some capacity, all the papers reviewed mention the importance of strong relationships, particularly inter-professional relationships (Thomson & Chatterjee, 2023) as key to effective collaboration, building trust and respect for one another (Leijten et al., 2018), which were argued to be necessary enablers of integrated (team) working. Erens et al (Erens et al., 2017b) in their evaluation of the

Integrated Care and Support Pioneer programme in England, emphasised the need to invest in building and maintaining good relationships for myriad reasons such as facilitating problem solving and a shared understanding of what the Pioneer Initiative, and the different organisations involved, were aiming to achieve. This was especially important in organisations where there were no previous relationships. The authors emphasise the benefits of strong legacy relationships, arguing that these bring stability and strength to collaborative attempts in an environment of changing staff, systems and changing commissioning arrangements.

Inter-organisational governance structures which support collaboration

Cameron et al (2014) report that, whilst enthusiasm and shared goals are important, these need to be underpinned by appropriate governance frameworks. In particular, clear financial and legal agreements about roles and responsibilities were important, alongside clear service level agreements to govern joint working. Piquer-Martinez et al (2024) in a review of 36 articles exploring models, theories and frameworks for health service integration identified eleven components common to all. They elucidated the importance of governance structures, or an '*organisational blueprint'* (p3) involving all stakeholders, in sustaining integration initiatives and in charting strategic direction. Piquer-Martinez et al noted that effective governance could be under mined by poor relationships, lack of effective communication, lack of shared accountability and vision/goals.

Miller et al (2021) review a decade of integration initiatives in the UK NHS and highlight issues which arise when formal governance arrangements are not in place, particularly lack of transparency and accountability for service delivery. This was also noted by Round et al (Round et al., 2018) in their qualitative evaluation of an integrated care programme in London which not did not achieve its aims. Respondents in their study bemoaned not knowing who did, or was responsible for, what, and that the lack of embedded governance systems allowed them to '*not own or contribute*' (ibid, p303). Miller at al (2021) also draw attention to the fact that collaborative forums and meetings are important in supporting the development of trust and shared goals. Most of the articles acknowledge the complexities and difficulties of bringing different organisations together not least their differing agendas, governance structures, goals and systems. Overcoming competing visions and agendas as noted by Cameron et al (2014) could introduce tensions and has the potential to deter rather than foster, trusting relationships on which initiatives dependent upon partnership working, are built.

However, the continuance of pre-existing governance arrangements could also be seen as limiting progress when implementing new models (Baxter et al., 2008), especially in the areas of contracting mechanisms, budgets and finances. Baxter et al's (2018) review covering 167 studies on the effects of integration and co-ordination between healthcare services and social care, also identified that attending to these challenges, and organisational change more generally, were not always explicitly addressed in integrated care models.

Processes for monitoring and performance review

All studies reviewed agreed that appropriate approaches to performance monitoring and review are important to ensure that integration goals are being met, but such monitoring is not necessarily straight forward. Kelly et al (2020) reviewed approaches to measuring the outcomes of integrated care, concluding that: '*Developing a consensus on core measurement sets however is challenging, not least due to complexity of establishing what an important outcome may be'* . Checkland et al (2021) concur, highlighting the fact that, whilst hospital avoidance is

often an important system goal, a focus on this alone risks devaluing important issues such as patient experience and satisfaction with services. Despite this complexity, Kirst et al (2017) emphasise the importance of an ongoing and dynamic understanding of care delivery and outcomes, allowing the adaptation of integrated care programmes to changing population needs, as well as for ensuing quality of care. However, it remains important that performance monitoring processes are appropriate and do not, in themselves, hinder collaboration (Ailsa Cameron et al., 2014).

Workforce support and processes

Most studies identified the importance of local processes to support the workforce, both in terms of practical measures to support staff working across boundaries and local processes which support rather than impede collaboration and integration. Key issues include:

- Processes to ensure that front line staff understand the relevant collaborative goals (Bhat et al., 2022)
- Working practices that allow trust to develop (eg co-location, the establishment of teams, collaborative activity towards a short term goal, clear professional roles/identity) (Kirst et al., 2017)
- Appropriate education and training to support inter-professional working (Thomson & Chatterjee, 2023)
- Good management, with local managers anticipating and managing difficulties as they arise (Bhat et al., 2022)
- Compatible HR processes and terms and conditions of service between different professional groups (Ailsa Cameron et al., 2014)
- Considering cultural practices (as well as process-oriented aspects of integration) are equally important to driving models of integrated care (Steele Gray et al., 2020).

Appropriate financial mechanisms and funding levels

In general, the facilitation of integrated working and integrated care provision requires organisations which receive funding through different mechanisms to collaborate, and appropriate means by which funding can be moved around (Bhat et al., 2022). This includes the pooling of budgets where necessary, but also requires payment mechanisms which do not favour one organisation or sector over another. For example, Miller et al (2021) draw attention to the fact that paying one sector according to activity whilst paying another a fixed sum generates problems and tends to skew activity. Similarly, Erens et al (2017a), Goodwin and Smith (2011), Steele Gray et al (2020) all argue for financial frameworks that support and encourage, rather than fragment, attempts at integration, where the inability to integrate financially and to unify budgets, is a significant barrier. So to is the availability of an appropriate level of stable and sustainable funding with implications for incentivising stakeholders to collaborate, providing adequate staff resources, and for longer-term planning, '*vital to preserve the ongoing functioning of integrated health systems*' (Bhat et al., 2022 p6). This was also picked-up by Lewis et al (2021) in a review of ten years of integration initiatives in the NHS, noting that that insufficient funding, and diminishing funding as programmes progressed, hampered integration activities.

IT systems and IG processes which support collaboration.

The centrality of IT interconnectivity, the importance of shared platforms and problems with incompatible IT systems were consistently mentioned across the literature as inhibiting the

joining-up and integration of services. A number of issues arise under this heading. Providing integrated care is facilitated by IT systems which allow easy data sharing between care providers for the benefit of staff and patients (Bhat et al., 2022), but this is not always straightforward to achieve. In particular, data sharing between different organisations can run into difficulties around data management and information governance processes, and where trust has not been established professionals may be reluctant to allow others to access their systems (Ailsa Cameron et al., 2014). Interoperable IT systems are also suggested to facilitate better communication between teams and professionals which in turn translates to more effective and trusting team working (for example see (Kirst et al., 2017; Leijten et al., 2018; Steele Gray et al., 2020)), important for effective communication across different organisations. This was also seen at local level between members of the same team and same organisation as reported by Neiva et al (2023), in their review of what factors drive success in integrated care in Brazil.

Communication processes to support collaboration

All studies highlight the importance of communication, with particular focus upon vertical communication between leaders and those who must work together, and horizontal communication between those sharing responsibility for care delivery (R.Q. Lewis et al., 2021). Kirst et al (2017) – amongst others - in a review of 12 articles about what works in integrated care programmes for older people, describe the feedback loop between good, open communication in facilitating trusting, relationships necessary for effective interdisciplinary collaboration and vice versa. Whilst good communication enhances team working (and is a key integration enabler according to the literature), poor communication impacts on factors such as team cohesiveness, productivity, information sharing, difficulties with co-ordination of services, case management and patient outcomes. The role of local managers is particularly important here, in both facilitating within-team communication and ensuring that frontline teams understand and buy into the overall vision (Bhat et al., 2022)

Mechanisms for engaging with the public

It is often claimed that engagement with the public is important in establishing more integrated services, in particular in order to ensure that the goals of any integration initiative meet public expectations for services (eg (Marjanovic et al., 2018)), but this is difficult to achieve and benefits difficult to evidence. Thomson et al (2023) highlight the importance of working with community groups and the public to co-produce new services, with Kirst et al (2017) also emphasising local programme flexibility to account for different population needs. However, exact role that public engagement should play in integration initiatives remains unclear.

Summary

There is remarkable agreement within the literature evaluating integrated care programmes and pilots and integrated working relating to health and care services as to their key enabling/inhibiting factors. Whilst different studies and reviews often use different terminologies, the underlying concepts that they reference remain very similar and we have provided the major tenets of these here, albeit in pared down detail. Delivering care which is experienced by patients as being integrated thus requires a complex mix of robust structures, processes, technical infrastructure and good leadership and management to facilitate the day-to-day realities of collaborative working and deliver a cohesive system. Trust across collaborating organisations fostered by good relationships within leadership teams and teams

delivering care is vital, alongside clarity over what the particular integration initiative is intended to achieve.

What is less clear from this literature is the optimum scope and scale of integration initiatives, and the role of planning and oversight authorities. Most evaluations address specific integration initiatives, which are usually instigated by local planning authorities across particular pre-determined geographical populations. As such, the role of the planning authority is rarely the focus of the evaluations. The existence of an external authority means that the scope and goals of integration pilots are, to some extent, externally set, although most of those assessed here also included the latitude to develop local priorities and plans. In their evaluation of a national integration pilot programme Checkland et al (2019) highlighted the importance of both local ownership and appropriate regional/national support and oversight, and suggested that this is particularly important where the conditions engendering the necessary inter-organisational trust (eg shared history (Coleman et al., 2010), knowledgeable local actors (Coleman et al., 2022)) are not initially present.

Commissioning for integrated service delivery

Looking across the commissioning and integration literature in this way provides an overview of what processes and conditions may be required if Integrated Care Systems are to successfully deliver integrated and effective services at Place level.

Our analysis suggests that the following conditions, processes and structures are likely to be necessary:

- ***Clarity as to the scope and scale of responsibility held within the local Place***, including clarity as to which bodies or individuals can make which types of decisions for which populations. If care is to be successfully integrated at this level, as a minimum it is likely that this responsibility will need to include the majority of services delivered outside hospitals, including community, primary and mental health care services. Some non-specialised hospital-delivered services may also need to be commissioned at this level.

- ***Mechanisms to establish local agreement*** as to relevant goals for local integrated services and to broker relationships between those who must work together. This requires a body with a good understanding of local needs, and appropriate processes to design services to meet those needs, ie ***a commissioning body.***

- ***Structures and governance***:
    - Appropriate formal Place-level structures to carry out local responsibilities eg a Place commissioning committee with a clear remit and decision-making power
    - Oversight mechanisms, including clear lines of accountability to System for local performance

- ***Leadership***:
    - One/more person in a leadership position within the commissioning body/committee with authority and the ability to facilitate the development of shared vision and goals, supported by a team of senior managers with relevant skills and experience

    - Clarity over the extent to which those in the leadership team who are employed by other organisations have authority to make commitments on behalf of their organisation

- ***Finance and resources***:
    - Clarity over budget, resources and responsibilities delegated to Place level.
    - Rules/incentives which support collaborative action (eg allow budget pooling), and absence of rules/incentives which inhibit it (eg competitive tendering)
    - Mechanisms for allocating responsibilities and resources from Place to local organisations which ensures that service providers have a clear understanding of what services they are expected to deliver, to what standard, within what budget

- ***Monitoring mechanisms*** for Place commissioners to use including:
    - Access to relevant performance data
    - Capability to understand and analyse data against the goals of integration
    - Mechanisms by which performance data can be fed into decisions about service design and organisation
    - Authority to intervene if services are not performing appropriately

- ***Mechanisms for engaging with the public*** to ensure services are appropriately adapted to meet a wide range of needs

Alongside these structures and processes (which largely mirror the elements of the expanded Commissioning Cycle), a number of enabling factors are necessary, including:

- ***Managerial staff*** with the necessary skills and experience to:
    - identify population needs
    - understand local service delivery
    - manage and broker relationships between the collaborating providers
    - oversee and support shared approaches to information governance and IT
    - foster effective multidisciplinary working

- ***Approaches to workforce development*** to:
    - Facilitate education and training to support integrated service provision.
    - Joint workforce planning.

- ***Data and information sharing***:
    - Ensure effective collection, sharing and utilisation of routine care and outcome data.
    - Common or inter-operable communication and IT platforms between providers and between providers and commissioners.

Conclusion

In this paper we have analysed both the literature on commissioning and the literature on the orchestration and delivery of integrated care and integrated working relating to health and care services to distil a set of commissioning requirements and tasks which underpin the delivery of locally integrated services. It is clear from the literature discussed that these requirements include both formal structures and processes which ensure clarity and accountability alongside approaches and ways of working which attempt to alleviate the

cultural and practical issues which may constrain working across boundaries. Underlying these elements is a need for clarity around the scope and scale of local responsibilities. Those responsible for overseeing local integration need to know for whom they are arranging which services, and, as highlighted in the international literature on strategic purchasing, they need to have the necessary information (about both population needs and service provision), resources and local political power to effect change, facilitate the development of trust and broker agreements between different providers. ***Taken together, these requirements suggest the need for a formal body at Place level with a clear remit for commissioning integrated services.*** Recent empirical evidence suggests that, while local Places may be making many decisions regarding the planning and provision of local services, there is a lack of clarity regarding their formal responsibilities (Sanderson et al., In press), and our preliminary conclusion is that this may represent an important gap in the current system.

Our ongoing data collection and analysis from case study sites in phase 2 of this study will focus upon the extent to which these requirements are present, and endeavour to draw more general lessons as to what local action and national policy direction and guidance may be required to facilitate and enable the effective delivery of local integrated services in the future. Our qualitative methods will allow us to explore both the formal structures and processes in each Place and the factors affecting how far the Places have the capacity and capability to deliver the complex working practices which allow the delivery of integrated care. We will also examine whether and how far the fact that Place-based authorities as currently constituted are not independent of the local population of provider organisations affects their operation, and consider the appropriateness of the geographies mapped to each Place.

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