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Health and social care systems and commissioning

NIHR Policy Research Unit in Health and Social Care Systems and Commissioning (PRU HSSC)

Delivering Integrated Neighbourhood services: understanding commissioning and service design within Places

Interim report

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Executive summary

Study aims and research questions
The overall aim of this study is to explore what commissioning structures and processes are required to oversee integrated care delivery at Place and Neighbourhood level to inform the development of ongoing policy and guidance.
The objectives are:

- To understand what commissioning processes and structures are required to deliver integrated care.
- To explore current established structures within ICSs to enable integrated care across the different ICS spatial levels.
- To understand how different organisational objectives and drivers are locally being managed to enable integrated care and by whom.

Research questions:

1. What does the evidence tell us about the commissioning and management processes required to support integrated care delivery?
2. What formal structures, support and management processes are being established to enable integrated care to be delivered within Places?
3. How can different contractual arrangements contribute to the delivery of integrated care within Places, and what oversight arrangements are required?
4. How do different approaches to primary, community, mental health and social care service commissioning, contracting and support affect the delivery of integrated care within neighbourhoods?
5. What policy or guidance would be helpful to local Systems and Places in supporting the development of commissioning structures and processes for local integrated care delivery?

Methods
***Work Package 1 (RQ1) (March-May 24*):** Literature mapping – commissioning tasks required to support integrated care delivery

A desk-based review of articles focusing on integrated care initiatives involving integration across organisational and sector boundaries, was conducted. 16 papers, including systematic reviews and published evaluations of large and smaller scale, national and international integration initiatives, were included. Findings from this review were synthesised with literature on healthcare commissioning previously published by the research team.

Work Package 2 September 2024 to June 2025 (RQ 2-5): Three ICS case study sites were purposefully identified and sampled. Six Places were selected across the three case study sites (2 in each ICS), in order to capture the impact of ICS decisions around delegation to Place level. Thirty-nine semi-structured interviews with members of the ICB executive team, Place stakeholders and Neighbourhood level staff across the three ICS case study sites were undertaken. In addition, we observed 65 relevant meetings at System and Place level where commissioning decisions and processes occurred.

Findings
RQ 1: What does the evidence tell us about the commissioning and management processes required to support integrated care delivery?

Our survey of the literature on commissioning and the delivery of integrated care highlights a number of important issues:

- There needs to be **clarity around roles and responsibilities**, with an overseeing authority able to set out clear goals for collaboration, make decisions about resource allocation and support organisations to work together across boundaries. This is heavily dependent upon good local relationships and requires skills in facilitation and brokering agreements, as well as the decision-making scope to manage difficult issues such as data sharing.
- **Goal-setting** for integrated services requires the ability to appropriately assess local population needs. There needs to be a balance between local and national priorities, without excessive national control of the agenda. This is important, because it is in developing and working towards collectively-defined goals that trusting relationships will thrive.
- **Leaders with vision** are required, supported by skilled managers with the resources and local insight and relationships to support collaborative working
- **Clarity is required around budget allocation**, with finance and procurement rules which facilitate and incentivise collaboration and do not impede it
- There need to be **mechanisms for monitoring activity and quality of services**, and some formal body needs authority to intervene if outcomes do not accord with goals.

Taken together, our assessment based upon the relevant literature is that **delivering integrated services across neighbourhoods requires a local commissioning body with formal authority to commission services.** This body needs to be constituted at an appropriate geographical scale which will allow the development of trusting relationships, and to have managers who can support work across organisational boundaries. The commissioning body requires the necessary authority, skills and resources to monitor service delivery and intervene if necessary. The commissioning literature suggests that most high-volume low complexity services (such as those delivered outside hospitals in neighbourhoods) should be commissioned over geographical populations small enough to allow commissioning managers to develop strong relationships with the multiple small-scale providers involved (Smith, Curry et al. 2010). This suggests **formal commissioning responsibilities should sit at what is currently called 'Place' level – sub-ICB geographical populations which often correspond to towns or metropolitan boroughs.**

Research Question 2: What formal structures, support and management processes are being established to enable integrated care to be delivered within Places?

Table i. Place-based structures in the three case study sites
Site A

Delegation to Place	Yes – budget and decision making
Local Structures	-Place-based committee, based on CCG footprint. Held in public, with subcommittees that feed into it. -Collaborative committees bringing together Place based organisations with an aim of focussing on local programmes of work.
Local Context	-The majority of the ICS budget is delegated to Places and therefore commissioners and commissioning decision-making operates at this level. -Accountability structures enable Places to make decisions based on local population need. Places feed into System level committees to ensure oversight of their working arrangements.

	-Alignment of LA and healthcare boundaries so that organisations can work together to plan services for their local populations. -Each Place operated differently. They had local collaboratives that brought together System partners to encourage integrated ways of working (not all were decision making committees).
Data	*'A simple answer is that Place is mapped around the [number of] local authority areas within [ICS name]. And that was chosen because we wanted to make sure that the previous commissioning organisations, the clinical commissioning groups, and councils were coterminous, so that we could look at the spend and the planning that we had together. And in doing so, we could deliver the statutory health and wellbeing strategy that local authorities are required to develop as part of their health and wellbeing board. It's also the case…so if we think about planning, spending, commissioning, the way we organise services, that works really, really well and people get it. It allows you to do all sorts of things with political and clinical, and managerial leadership at scale within that Place.* *We also though…so that's the straightforward answer that, there's a more sophisticated answer, which is we believe in subsidiarity. Which means you deal with the issue as close to the person as possible'. (P0030cq)*

Site B

Delegation to Place	**No**
Local Structures	-No formal Place based arrangements and committees at the time of the research. -Collaborative committees, held at system level, bring together health and system wide partners including local authority, social care, and the voluntary sector to collectively focus on planning, strategy etc., for programmes of work aligned to organisational plans and priorities, both system wide and locally. - Regular joint commissioning committees held for each Place to work on statutory joint arrangements. Chaired by the local authority and involving partners from across health, social care, and voluntary sector.
Local Context	-NHS commissioners sit at System level where decision making happens and services are delivered at Neighbourhood level. There is a gap between decision makers and implementors. Commissioning work was undertaken across different programmes i.e. Primary Care, acute care etc. This made geographical-based collaboration across work programmes difficult to achieve. - This System was grappling to articulate what Place means to them and how to work within existing structures that have been established.
Data	*'So, I think…I still don't think we've quite got there with Place yet about what we…I think we've gone through a period of trying to understand what it means to us that's different to what we've already got. Because if you say Place is a commissioning construct, we already have our joint commissioning boards. If you say Place is based on the Thriving Place guidance, then it's a much wider partnership group.' (P0018)*

Site C

Delegation to Place	**No-commissioning managers initially situated at Place level, but no formal delegation of funding. Staff moved up to ICB level when managerial costs reduced**

Local Structures	Place-based structures based upon local authority footprints, made up of sub-groups based upon district authority areas Two regular committees at place-level both chaired by local authority and involving partners from across health, social care, and voluntary sector One system-wide oversight board to monitor and plan integrated working at place level
Local Context	-Site C initially began with around ¾ of the ICB workforce being located at Place, to provide commissioning oversight for the jointly agreed strategy. -However, a 30% reduction in management costs led them to take resource and responsibility out of Place and centralise it into System level. This left a structure in which Place and Neighbourhood levels were strategic in terms of their footprint and relationships but hollowed out in terms of their capacity to deliver commissioning activity. The job of managing place has then become one of attempting to negotiate a fit between strategic priorities agreed at System level and demographic and operational realities at Place.
Data	*Going back 18 months or more, we had Place-based teams. So, within the ICB, we had a Place-based team…something of the order of all the ICB staff, 70 per cent Place, 30 per cent [ICB name]. And so, at a Place level, we had partnerships team, we had urgent care, planned care, community, all of those things that could deal directly with the relevant providers…and work on that. And what happened 18 months ago is the national requirements reduced by 30 per cent. In achieving that 30 per cent reduction, we've, sort of, flipped that split on its head and now…probably 80 or 90 per cent pan-[System] and a very small Place-based team. I mean, to put it into perspective, the Place-based team for [Place Name] is me and one other person. Everything else is pan-[System]…And the Place-based team… my role is very much to look across those pan-System workstreams. So… primary care, mental health, planned care, community, all of those things are really across all of those work streams, so right okay, that's great but how do things hang together for the [Place] population?…Because invariably, my [System]-wide colleagues who are commissioning at a functional workstream level, they're talking about the same people, they don't know if, you know, patient X is in the primary care workstream, the mental health workstream, is on an elective care waiting list. It's that thing. So that's the mechanics of it…making sure they can draw across those to say, so this is how it stacks up for each of the three Places, so we can still give that assurance to local Place-based partners. So, we've got our Place-based health and wellbeing boards…we're still held to statutory scrutiny through health scrutiny committees at the Place level. (P0039hs)*

Formal structures at Place level were variable and changed during the fieldwork period. The variability was driven by different perspectives as to how commissioning should be undertaken and different understandings of what Place was for, and these differences in turn arose out of differing histories and experiences.

- Site A has paid most attention to developing commissioning structures at Place level, driven by their early decision to delegate commissioning responsibilities to this level.
- The decision in Site B to arrange commissioning around programmes of work rather than geographically led to a structure by which commissioning support was aligned

with programme committees. The committees themselves had no commissioning powers, rather they made recommendations which were then agreed by ICB strategy and finance committees before being enacted by centralised commissioners. There were limited formal structures at place level, beyond longstanding joint commissioning arrangements with Local Authorities. Internal discussions about the meaning and role of Place were ongoing.

- In Site C, the reduction in managerial costs had led to the withdrawal of all but one or two commissioning managers from Place level, with a corresponding reliance upon provider alliances to sub-contract and take over operational commissioning responsibilities.

Research questions four and five

Our next two research questions focused upon the mechanisms by which local Places were commissioning services. We did not find any use of innovative or novel approaches to commissioning. Indeed, commissioning activity was relatively limited, as Systems and Places focused upon working out how they should operate.

Helpful factors for local integration activity:

- A clear focus
- Good data management and linked data
- Clear role and remit
- Good long-term relationships

Factors that hindered local integration activity:

- Loss of clinical voice
- Service pressures
- Multi-level decision making processes, with lack of clarity around where responsibilities lie
- Individual organisational sovereignty. This was particularly important in the context of multilevel decision-making processes – where collaborative committees do not have decision-making powers, there tends to be a default towards individual organisational decision-making
- The loss of the language of commissioning was identified by some as problematic, as it reduced focus on the necessary tasks to achieve service change

Case study Summary: to what extent are the factors identified as being important for the commissioning of integrated services present?

Table 5 sets out a brief overview of the extent to which we found the factors identified in our literature review within our case study sites:

Table ii: The presence/absence of the factors needed to support the commissioning of integrated services

Factors needed to support commissioning of integrated services	Findings from case study sites
Clarity over roles and decision making	Present where formal delegation of commissioning responsibilities has taken place, not present otherwise. A degree of confusion over who is responsible for what in some areas and multiple layers of decision-making present in most areas
Managers with skills and local insight to support and broker relationships	Managerial support good and valued, but concerns over cuts to management budgets. Areas which had worked together in the past at a considerable advantage
Allocated budget, and incentives to support collaboration	One out of three sites had formally delegated funding. In other sites financial decision making remains at ICB level. Individual organisational incentives to maintain financial balance remain problematic for collaboration
Ability to set appropriate local goals	Lack of clarity over responsibility for local decision making makes goal-setting complex. Perception that local decisions could be second-guessed at higher levels, with associated loss of momentum.
Skilled leadership	Good leaders acknowledged, but concern over loss of clinical leadership in some areas, with service pressures identified as preventing engagement
Appropriate geographical coverage to facilitate local relationships and engagement	Sites where Places have worked together previously and are co-terminus with local authorities see Place as the natural level at which integrated working can be supported. Where Places are not functioning, the ability to link with local authorities is more limited.
Good understanding of local population needs and capacities and capabilities of local providers	Recognition of the importance of these standard commissioning functions, but concern that they have been somewhat hampered by the loss of the language of commissioning. Concern over managerial budget cuts and loss of local insight.
Mechanisms for monitoring services and outcomes	

Discussion

- The factors identified from the literature as being necessary for the effective commissioning of integrated services were only present to a limited extent.
- Lack of clarity around roles, responsibilities and decision making was particularly important.
- Formal delegation of responsibilities to Place level was helpful in facilitating local integration activity
- Where formal delegation of responsibilities had not occurred, committees could only make recommendations, and any proposed changes had to be signed off by higher level committees. This tends to lead to organisations defaulting to a position which prioritises individual organisational priorities because these are the ones over which they have authority.
- Skilled managers were present and valued, but there was concern over the requirement for ICBs to significantly reduce managerial costs.
- Effective collaboration requires a 'human scale', in which individuals know and trust one another. Those areas where local geographies had been stable for a number of

years were at an advantage, as individuals in different sectors had built relationships over time, supporting their ability to collaborate.
- The site which had decided to organise service development by programme rather than by geography subsequently experienced some difficulties in articulating the role and remit of Place in their System. This could be problematic, particularly when service development required liaison across geographical areas with Local Authorities and other locally-based service providers, and where service integration required an approach which cut across programme remits.
- Respondents acknowledged the importance of traditional commissioning activities such as needs assessment and monitoring of service outcomes.

In summary, we found that following the Health and Care Act 2022 there was a loss of focus on the tasks of commissioning and some confusion as to how service development and management functions should be organised. Delegation of decision-making and funding to Place level in one area provided clarity but also introduced some new constraints in the form of additional layers of oversight. In other areas decision-making was retained at ICB level, constraining the ability of local Places to make meaningful changes to their local services. The lesson from the literature on developing more integrated services is that clear locally agreed goals and decision-making processes are vital; our study suggests that that clarity is currently lacking.

Implications for the implementation of the 10 Year Health Plan
Our study suggests a number of factors which could usefully be considered in the implementation of these plans:

- **Greater clarity is required around responsibilities and decision-making powers within ICBs below Board level**.
- **Clarification of the appropriate geographical scale over which particular types of services should be commissioned and overseen is urgently required.**
- The Plan does not address explicitly the nature of commissioning arrangements for Neighbourhood-based services; **our study suggests that this responsibility would be most effectively carried out at Place level**
- If **large-scale providers are intended to act as local commissioners, attention is required to the relevant evidence about the operation of lead or prime-provider contracts**
- Under current arrangements respondents told us that meaningful joint decision-making was hampered by the fact that ownership of budgets remained with individual organisations; large-scale pooled budgets may address this. **However, a large scale pooled budget would require strong governance and accountability mechanisms, with appropriate mechanisms to support priority setting.**
- **Effective inter-organisational integration and collaboration requires investment in managerial capacity and skills**
- **Place is important.** The focus of the 10 year Plan is on delivery at Neighbourhood level; our study suggests that high quality delivery in Neighbourhoods requires appropriate commissioning structures at Place level, and operational guidance about how this should operate is required
- If contracts are to be the main means by which services are procured and delivered, a return to clear language around commissioning is necessary.
- Even if significant elements of commissioning responsibilities are handed over to large scale providers, **independent commissioning managers will still be required**

Introduction

The Health and Care Act 2022 was introduced to deal with what was perceived to be a fragmented health care system which was failing to deliver joined up care to the population (NHS England 2020). The Act established 42 Integrated Care Boards (ICBs) as the statutory commissioners of health care services for geographical populations in England, with responsibility for orchestrating a more integrated approach to service delivery. Whilst there has been a change of government since the Act came into force, there remains a consistent focus on optimising the health care system to support more integrated services, with a greater proportion of care delivered in the community by provider organisations working together across organisational and sector boundaries (Department of Health and Social Care 2021, Department of Health and Social Care 2023). The recent 10 Year Health Plan (Department of Health and Social Care 2025) reiterates these priorities, focusing upon three significant 'shifts' to create a more resilient NHS: shifting care from hospitals into the community; shifting from an analogue to a digital approach to delivering care; and shifting from a focus on treatment to prioritising prevention of ill health. These shifts are to be delivered by, amongst other things, a focus upon the creation of 'neighbourhood health services' providing treatment and preventative services close to peoples' homes.
The focus of this research project has been upon the commissioning structures and approaches required within ICBs to deliver the more integrated services envisaged by policy. Whilst the project predates the recently-published 10 Year Health Plan, the research questions that we have addressed to date are pertinent for the delivery of the Plan. This Interim Report sets out our findings to date and draws out their relevance to the ambitions set out in the Plan; the next phase of the project will focus upon the changes necessary to implement neighbourhood services.

The structure of the report is as follows. We first provide a summary of the background and rationale for the project, followed by our aims and research questions. We then provide an overview of our methods, followed by a brief summary of the findings from our initial literature review. We then set out the findings from our qualitative case studies, finishing with a discussion which sets our findings in the context of the recent 10 Year Health Plan.

Background and rationale for the project

Notwithstanding the emphasis on the need for greater collaboration and cooperation within the NHS, the Health and Care Act 2022 left in place an underlying architecture by which responsibility for the commissioning of services is separated from responsibility for service provision. Under the Act, ICBs took over the statutory responsibility for commissioning services according to contracts with a range of local providers which had previously been held by Clinical Commissioning Groups. However, ICBs were established covering geographical populations considerably larger than those of previous statutory commissioners, with 42 ICBs replacing around 200 Clinical Commissioning Groups. In managing this shift in the geographical scale over which commissioners are required to act, policy and guidance (Department of Health and Socical care 2021, NHS England 2021, NHS England 2021) suggested that most day-to-day commissioning activity should take place at what has come to be called 'Place' level: sub-ICB geographical footprints which will usually be co-terminous with Local Authorities, and which represent 'natural communities' within which people live their lives (NHS England 2021). However, in contrast to the approach taken in previous legislation such as the Health and Social Care Act 2012 (Health and Social Care Act 2012),

under which roles and responsibilities of each organisation were clearly specified (Department of Health 2011), the 2022 Act took a permissive approach, allowing each ICB to decide for itself how it would discharge its commissioning responsibilities (Sanderson, Osipovic et al. In press). In particular, ICBs were offered a range of different approaches to working at Place level, from the establishment of formal delegation of responsibilities to commissioning committees, to a much looser arrangement by which a single 'Place leader' could convene working groups to provide advice and input to commission decisions made by the ICB (NHS England 2021).

Against this background, our study set out to explore how ICBs were discharging their responsibility to commission local integrated services. Our focus was at Place level for two reasons: this is the level to which guidance suggested that most day-to-day commissioning responsibilities should be delegated; and it is the geographical scale across which routine commissioning has historically taken place (Lorne, Allen et al. 2019). The study included two phases. Firstly, we used the literature on commissioning and the literature on integrated care to synthesise what is known about how to commission integrated care. Secondly, we undertook qualitative case studies in a number of ICBs, exploring the commissioning arrangements established in local Places and the approach taken to commissioning services. It was intended that data collection for this phase would continue until the end of 2025, in order to capture changes in commissioning arrangements as they developed over time. However, the publication of both a new 'Model Blueprint' for ICBs (NHS England 2025) and the 10 Year Health Plan in June 2025 provided a natural reflection point, as both suggest significant changes in the way that ICBs carry out their roles. In September 2025 the 'Model Region' blueprint (NHS England 2025) further highlighted the extent to which roles and responsibilities within the NHS and Department of Health and Social Care are changing, reinforcing the need for a period of reflection as to what we currently know that is relevant to delivering the ambitions in the 10 year Health Plan. We are therefore reporting on our initial findings, in order to provide feedback to policy makers which may be useful in the next phase of implementation of the Plan.

Study aims and research questions

The overall aim of this study is to explore what commissioning structures and processes are required to oversee integrated care delivery at Place and Neighbourhood level to inform the development of ongoing policy and guidance.
The objectives are:

- To understand what commissioning processes and structures are required to deliver integrated care.
- To explore current established structures within ICSs to enable integrated care across the different ICS spatial levels.
- To understand how different organisational objectives and drivers are locally being managed to enable integrated care and by whom.

Research questions:

6. What does the evidence tell us about the commissioning and management processes required to support integrated care delivery?
7. What formal structures, support and management processes are being established to enable integrated care to be delivered within Places?

8. How can different contractual arrangements contribute to the delivery of integrated care within Places, and what oversight arrangements are required?
9. How do different approaches to primary, community, mental health and social care service commissioning, contracting and support affect the delivery of integrated care within neighbourhoods?
10. What policy or guidance would be helpful to local Systems and Places in supporting the development of commissioning structures and processes for local integrated care delivery?

Methods

The aim of the study was to explore what commissioning structures and processes are required to be implemented to enable integrated care delivery at Place and Neighbourhood level within ICSs.

We undertook a qualitative study with two work packages. Initially we focussed on utilising existing evidence to understand what commissioning and management processes are required to enable integrated care delivery. This was then followed by detailed qualitative case study work of 2 ICSs and one supplementary ICS to substantiate our findings across England. We undertook interviews with key stakeholders across all three spatial levels within ICSs alongside observations of ICS and Place level meetings focussing on the commissioning and delivery of services. This allowed us to explore local commissioning structures and processes being utilised to support the implementation of integrated care.

***Work Package 1 (RQ1) (March-May 24*):** Literature mapping – commissioning tasks required to support integrated care delivery

A desk-based review of articles focusing on integrated care initiatives involving integration across organisational and sector boundaries, was conducted. 16 papers, including systematic reviews and published evaluations of large and smaller scale, national and international integration initiatives, were included. 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 proposed in the NHS in England. 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. Themes were developed capturing inhibiting/enabling and supportive components of an integrated care initiative. To ensure reliability, these were tested against a wider body of literature relating to integrated care. Finally, findings from this review were synthesised with literature on healthcare commissioning previously published by the research team.

Work Package 2 September 2024 to June 2025 (RQ 2-5): Three ICS case study sites were purposefully identified and sampled based on the following criteria:

- ICS progress (maturity of a System vs newly forming Systems)
- Places aligned to Local Authority boundaries vs Places not aligned to Local Authority boundaries
- Have at least two Places
- Delegated commissioning responsibility to Place vs Systems leading the commissioning process
- Geographical location and footprint

- Previous case study research sites. There is merit in continuing research with sites previously involved as this will add the dimension of continuity to examining how new processes and functions are being implemented across the ICSs

Six Places were selected across the three case study sites (2 in each ICS), in order to capture the impact of ICS decisions around delegation to Place level.

Table 1 ICS sites

	Site A	Site B	Site C
Geographical Region	North	Midlands	South
Population size	Between 2-3 million	Between 1-2 million	Between 1-2 million
Place is defined	Yes	No	Yes
Delegation to Place	Yes	No	No

Thirty-nine semi-structured interviews with members of the ICB executive team, Place stakeholders and Neighbourhood level staff across the three ICS case study sites were undertaken. The purpose of these interviews was to explore the role of Place and local integrated care programmes across the three geographical spatial levels within ICSs. Interviews with ICB executive team were employed to understand: System wide governance structures and processes of commissioning, including schemes of delegation; to understand contractual arrangements which are being employed to deliver integrated care; explore the governance relationships between Systems and Places and how these impact on integrated care delivery; explore which levels of the System are accountable for contractual decision making and oversight and explore what formal and informal structures and processes of commissioning encourage integrated care delivery.

Within each case study Place, interviews with key stakeholder were undertaken to understand how local integrated services were being commissioned. Interviews explored how integrated personalised services are being developed and established, with a particular focus upon: support structures and commissioning roles; decision making powers; approaches to collaboration between health and care providers; contractual and other mechanisms underpinning local collaborations and perceived progress, and other factors affecting progress both positively and negatively.

Findings from our literature review, relating to both commissioning and management of integrated care, underpinned case study data collection. The findings from the literature, provided a framework to guide data collection, topic guide development and analysis.

In addition, we observed 65 relevant meetings at System and Place level where commissioning decisions and processes occurred. These were selected based on data generated from both System and Place level interviews. The observations were undertaken to understand local commissioning arrangements and structures in operation across the case study sites. Observations were employed to observe how commissioning decisions and functions are enacted between different System partners responsible for delivering integrated care.

Table 2: data collection in each site

	Interviews	Observations
Site A	19	30
Site B	17	30
Site C	3	5
Total	39	65

Analysis was undertaken following a framework analysis approach. A coding framework was initially developed by all members of the research team, focussing on codes that reflected the research questions and the main findings from the literature review. Data collection and analysis were conducted in parallel to allow findings to inform on-going data collection.

Findings

WP 1-Literature Review: What do we know about commissioning for integrated care?

This section provides a summary and overview of our previously submitted Literature Report.

Background

Whilst the relevant policy documents emphasise the importance of collaboration and joint working, it is important to highlight the fact that the 2022 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, Allen 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, Charles 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 and Williams 1997). 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, Powell and Mohan 1999, Mays, Mulligan and Goodwin 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,

Greener 2009, Department of Health 2011). 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, Allen et al. 2020), but despite changes in regulations, the extent to which services were actually competitively procured remained limited (OsipoviČ, Allen et al. 2016). The extent to which local clinicians (usually GPs) have had a role in commissioning has varied over the years (Miller, Peckham et al. 2015). The 2012 Heath and Social Care Act gave them an important role, establishing Clinical Commissioning Groups as membership organisations of GPs. However, this role was removed in the 2022 Health and Care Act, with GP involvement reduced to the potential appointment of a representative to an Integrated Care Board. The extent to which clinical engagement is an important contribution to successful commissioning remains unclear, although there is some evidence that clinicians can had value in some circumstances (McDermott, Coleman et al. 2014).

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 and 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 (Glasby 2012, Allen, Checkland et al. 2020). 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, Allen 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, Allen et al. 2019, Sanderson, Allen et al. 2020).

What is commissioning?

Commissioning derives from Ovretvreit's purchasing framework (Øvretveit 1993), which describes the cyclical process of strategic service planning including needs assessment, planning, contracting, monitoring and review. The resulting 'commissioning cycle' has underpinned service development in the NHS in England for many years (Department of Health 2007). A considerable body of research on commissioning exists (e.g. (Chappel, Miller et al. 1999, Bravo Vergel and Ferguson 2006, Davies 2007, Baxter, Weiss and Le Grand 2008, Curry, Goodwin et al. 2008, Checkland, Harrison et al. 2012, Bovaird, Briggs and Willis 2014)). A recurring theme is the extent to which transactional approaches common in the private sector – whereby marketisation supports frequent shifting of contracted provision – are inappropriate within a publicly funded service where market failure would be disastrous. This literature highlights the importance of a relational approach, where commissioners and providers work together to optimise services and health outcomes (Allen 2002).

Wade et al (Wade, Smith et al. 2006) studied commissioning by Primary Care Trusts. Whilst NHS structures have changed, the underlying architecture of service planning remains the same, and these activities therefore remain relevant:

- Objective setting and decision making, including: balance between national/regional/local objectives; mechanisms for setting local objectives; clarity over scope of decision-making powers; governance structures by which they can be held to account
- Facilitation and management of partnerships across their geographical footprint
- Supporting patient choice
- Information collection and analysis, including: population health needs; service maps; provider activity and quality data; patient satisfaction data; and intelligence about factors affecting demand.
- Service design and resource allocation, with some more specialised services designed and delivered over larger footprints by consortia of commissioners.
- Procurement and contracting, including: service specifications which take account of evidence as well as local service provider capacity and capability; contracting procedures; contract monitoring; quality improvement; performance management.

In addition, reviews have highlighted the fact that the geographical scale over which commissioning should take place depends upon a trade-off between the need for local knowledge, relationships and responsiveness to fine-grained assessments of need, and the requirement for risk-sharing and increased commissioner power for more specialised services or larger scale reconfigurations (Curry, Goodwin et al. 2008, Smith, Curry et al. 2010, Sheaff, Chambers et al. 2013). The scale of commissioning organisations in comparably developed health care systems, in terms of the population size they commission for, varies considerably between different country contexts, reflecting differing governance preferences as well as the particular socio-economic, geographical, historical and political contexts of each country. When focused on local service commissioning, particularly primary care, there is a broad tendency to commission for populations of between 100,000 and 1.5 million with many countries clustered in the region of 200,000 to 800,000 people (Tikkanen, Osborn et al. 2020, Australian Government Department of Health 2025). Organisations commissioning for over 3 million people are unusual, although this includes the English NHS's largest ICSs (https://www.health.org.uk/reports-and-analysis/briefings/integrated-care-systems-what-do-they-look-like). Organisations commissioning for significantly smaller populations, e.g. approximately 50,000 people, tend to reflect particular geographic challenges or federalist administrative arrangements (Tikkanen, Osborn et al. 2020).

Integrated service delivery

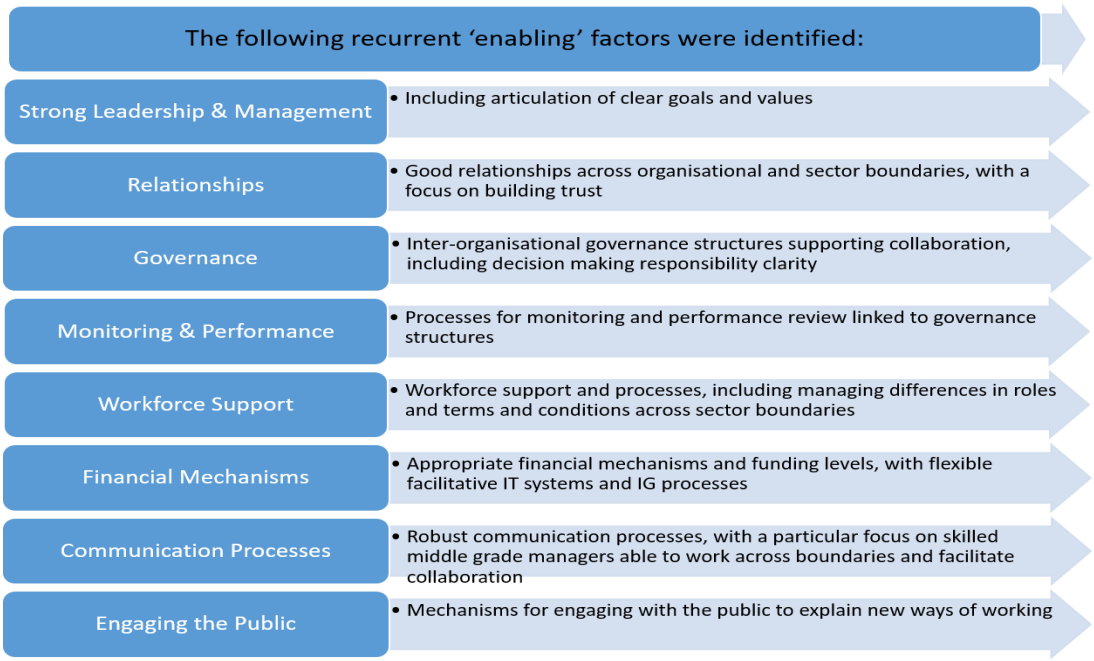
'Integrated care' is often poorly defined, with one article identifying more than 175 overlapping definitions (Armitage, Suter et al. 2009). The NHS Long Term Plan (NHS England 2019 p12) references: 'more joined-up and coordinated … care' and 'breaking down traditional barriers between care institutions, teams and funding streams', while an initial ICS 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 2019 p1). A review of integration initiatives in the NHS (Lewis, Checkland et al. 2021) highlighted the ambiguity at the heart of many 'integration' initiatives, concluding that efforts to improve patient experiences should focus upon care co-ordination across organisational, professional and geographical boundaries. It is this conceptualisation of integration that is foremost in the 10 Year Health Plan, with a strong focus on 'a single, coordinated, patient-orientated service ' (Department of Health and Social Care 2025 p9) We explored review articles and published evaluations of national and international integration initiatives, focusing upon those involving integration across organisational and sector boundaries (Table 1). Recurrent 'enabling' factors were identified as per Figure 1:

Table 3: Included literature

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
Checkland K et al	2022	UK	National Evaluation of the Vanguard New Care Models Programme: Final Report. Manchester, England: University of Manchester; 2022.
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
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
Steele Gray et al	2020	Canada, New Zealand, Netherlands	Comparing International Models of Integrated Care: How Can We Learn Across Borders?

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

Figure 1: Synthesis of integration literature



Overall, the international literature suggests clarity over roles and responsibilities as well as the vision and goals underpinning integration initiatives are important. Trust across organisational boundaries is vital, requiring active mechanisms and skilled managers to build and maintain it.

Synthesis: Research question 1

Our first research question is as follows: *What does the evidence tell us about the commissioning and management processes required to support integrated care delivery?*
Our survey of the literature on commissioning and the delivery of integrated care highlights a number of important issues:

- There needs to be clarity around roles and responsibilities, with an overseeing authority able to set out clear goals for collaboration, make decisions about resource allocation and support organisations to work together across boundaries. This is heavily dependent upon good local relationships and requires skills in facilitation and brokering agreements, as well as the decision-making scope to manage difficult issues such as data sharing.

- Goal-setting for integrated services requires the ability to appropriately assess local population needs. There needs to be a balance between local and national priorities, without excessive national control of the agenda. This is important, because it is in developing and working towards collectively-defined goals that trusting relationships will thrive.
- Leaders with vision are required, supported by skilled managers with the resources and local insight and relationships to support collaborative working
- Clarity is required around budget allocation, with finance and procurement rules which facilitate and incentivise collaboration and do not impede it
- There need to be mechanisms for monitoring activity and quality of services, and some formal body needs authority to intervene if outcomes do not accord with goals.

Taken together, our assessment based upon the relevant literature is that delivering integrated services across neighbourhoods requires a local commissioning body with formal authority to commission services. This body needs to be constituted at an appropriate geographical scale which will allow the development of trusting relationships, and to have managers who can support work across organisational boundaries. The commissioning body requires the necessary authority, skills and resources to monitor service delivery and intervene if necessary. The commissioning literature suggests that most high-volume low complexity services (such as those delivered outside hospitals in neighbourhoods) should be commissioned over geographical populations small enough to allow commissioning managers to develop strong relationships with the multiple small-scale providers involved (Smith, Curry et al. 2010). This suggests formal commissioning responsibilities should sit at what is currently called 'Place' level – sub-ICB geographical populations which often correspond to towns or metropolitan boroughs.

WP 2-Case study findings

Research Question 2: What formal structures, support and management processes are being established to enable integrated care to be delivered within Places?

Although national guidance suggested that Place should be the geographical level at which most routine commissioning activity should be accomplished, ICBs were given discretion to develop their sub-Board structures as they saw fit (NHS England 2021). As a result, we found considerable variation across our case study sites. In addition to this, we found that national changes, such as changes to ICB workforce and management resource (NHS England 2025) has influenced the ways in which some Systems have chosen to operate due to workforce capacity issues, resulting in ongoing changes during the fieldwork period.
The key variable underpinning how Systems have organised themselves at Place level is the extent to which decision making, workforce or resources have been formally delegated to Place. This in turn affected the design of committee structures and governance arrangements. If no decision-making responsibility was held at Place, there was less need for formal committees to be established. Table sets out the Place-based structures in each of our sites.

Table 4: Local Place-based Structures

Site A

Delegation to Place	Yes – budget and decision making
Local Structures	-Place-based committee, based on CCG footprint. Held in public, with subcommittees that feed into it. -Collaborative committees bringing together Place based organisations with an aim of focussing on local programmes of work.
Local Context	-The majority of the ICS budget is delegated to Places and therefore commissioners and commissioning decision-making operates at this level. -Accountability structures enable Places to make decisions based on local population need. Places feed into System level committees to ensure oversight of their working arrangements. -Alignment of LA and healthcare boundaries so that organisations can work together to plan services for their local populations. -Each Place operated differently. They had local collaboratives that brought together System partners to encourage integrated ways of working (not all were decision making committees).
Data	*'A simple answer is that Place is mapped around the [number of] local authority areas within [ICS name]. And that was chosen because we wanted to make sure that the previous commissioning organisations, the clinical commissioning groups, and councils were coterminous, so that we could look at the spend and the planning that we had together. And in doing so, we could deliver the statutory health and wellbeing strategy that local authorities are required to develop as part of their health and wellbeing board. It's also the case…so if we think about planning, spending, commissioning, the way we organise services, that works really, really well and people get it. It allows you to do all sorts of things with political and clinical, and managerial leadership at scale within that Place.* *We also though…so that's the straightforward answer that, there's a more sophisticated answer, which is we believe in subsidiarity. Which means you deal with the issue as close to the person as possible'. (P0030cq)*

Site B

Delegation to Place	No
Local Structures	-No formal Place based arrangements and committees at the time of the research. -Collaborative committees, held at system level, bring together health and system wide partners including local authority, social care, and the voluntary sector to collectively focus on planning, strategy etc., for programmes of work aligned to organisational plans and priorities, both system wide and locally. - Regular joint commissioning committees held for each Place to work on statutory joint arrangements. Chaired by the local authority and involving partners from across health, social care, and voluntary sector.
Local Context	-NHS commissioners sit at System level where decision making happens and services are delivered at Neighbourhood level. There is a gap between decision makers and implementors. Commissioning work was undertaken across different

	programmes i.e. Primary Care, acute care etc. This made geographical-based collaboration across work programmes difficult to achieve. - This System was grappling to articulate what Place means to them and how to work within existing structures that have been established.
Data	*'So, I think…I still don't think we've quite got there with Place yet about what we…I think we've gone through a period of trying to understand what it means to us that's different to what we've already got. Because if you say Place is a commissioning construct, we already have our joint commissioning boards. If you say Place is based on the Thriving Place guidance, then it's a much wider partnership group.' (P0018)*

Site C

Delegation to Place	**No-commissioning managers initially situated at Place level, but no formal delegation of funding. Staff moved up to ICB level when managerial costs reduced**
Local Structures	Place-based structures based upon local authority footprints, made up of sub-groups based upon district authority areas Two regular committees at place-level both chaired by local authority and involving partners from across health, social care, and voluntary sector One system-wide oversight board to monitor and plan integrated working at place level
Local Context	-Site C initially began with around ¾ of the ICB workforce being located at Place, to provide commissioning oversight for the jointly agreed strategy. -However, a 30% reduction in management costs led them to take resource and responsibility out of Place and centralise it into System level. This left a structure in which Place and Neighbourhood levels were strategic in terms of their footprint and relationships but hollowed out in terms of their capacity to deliver commissioning activity. The job of managing place has then become one of attempting to negotiate a fit between strategic priorities agreed at System level and demographic and operational realities at Place.
Data	*Going back 18 months or more, we had Place-based teams. So, within the ICB, we had a Place-based team…something of the order of all the ICB staff, 70 per cent Place, 30 per cent [ICB name]. And so, at a Place level, we had partnerships team, we had urgent care, planned care, community, all of those things that could deal directly with the relevant providers…and work on that. And what happened 18 months ago is the national requirements reduced by 30 per cent. In achieving that 30 per cent reduction, we've, sort of, flipped that split on its head and now…probably 80 or 90 per cent pan-[System] and a very small Place-based team. I mean, to put it into perspective, the Place-based team for [Place Name] is me and one other person. Everything else is pan-[System]…And the Place-based team… my role is very much to look across those pan-System workstreams. So… primary care, mental health, planned care, community, all of those things are really across all of those work streams, so right okay, that's great but how do things hang together for the [Place] population?…Because invariably, my [System]-wide colleagues who are commissioning at a functional workstream level, they're talking about the same people, they don't know if, you know, patient X is in the primary care workstream, the mental health workstream, is on an elective care waiting list. It's that thing. So that's the mechanics of it…making sure they can draw across those to say, so this is how it*

	stacks up for each of the three Places, so we can still give that assurance to local Place-based partners. So, we've got our Place-based health and wellbeing boards…we're still held to statutory scrutiny through health scrutiny committees at the Place level. (P0039hs)

Overall, therefore, in our three case study systems, formal structures at Place level were variable and changed during the fieldwork period. The variability was driven by different perspectives as to how commissioning should be undertaken and different understandings of what Place was for, and these differences in turn arose out of differing histories and experiences. Despite these differences the actual mechanisms by which joint activity to deliver more integrated care was undertaken within Places remained the same as those used by CCGs, including Section 75 agreements and joint programmes of work. We did not find any examples of new ways of working together enabled by the Act; rather we found that service delivery rolled forward in very similar ways to previously, whilst ICBs worked out what their structures and processes should be. In one of our sites the reduction in managerial resources available to ICBs had resulted in the reduction of active commissioning activity at Place level.

In terms of managerial support, this again depended upon the extent to which responsibilities had been delegated to Place level. Within Site A, their respective Places operated differently based on historical ways of working, local working arrangements and relationships. In Place A1, they have established a partnership committee to bring commissioners and providers together to encourage system wide representation and decision making. This committee has oversight over numerous programmes of work, such as primary care, mental health, planned and unplanned care. In Place A1, the leader spoke about the importance of blurring the lines between commissioners and providers to ensure that there is accountability for the spending but an acknowledgement that you need to work in partnership to ensure that service planning and delivery is feasible. The commissioner in this Place was described as performing a supportive role, bringing together system partners to work differently and bring about change for local populations. It is important to note, that the governance arrangements and ways of working, focussed solely on the local Place NHS budget.

> *'Well, it's obviously moved over the last 15 years, so there used to be, when I first came into this world, a very clear divide between providers and commissioners, and it used to be called clear blue water, you know, there couldn't be any conflict between who was making the commissioning decisions, compared to who was delivering them. But the reality is, you can't commission in isolation without understanding what the actual realities are operationally, and to do so comes at some significant risk of not really understanding how to genuinely join up integrated care. So we've got to be brave in this new world, and actually the planning guidance gives us a lot more delegation into providers, we've got to try shared roles, which is what we've done for a long time at [Place], joint roles. You'll see what we try to with our alliances is, it's not about just having a group of partners that come together. To support them they will have commissioners…So I think that blurring is really important, because you can still be accountable for the decision and the money, which is our role, as the ICB, but you've got to be guided by what will work, what are the expertise, which includes patients and the people that deliver service'. (P006vn)*

In Place A2, a Place based partnership committee has also been developed comprising leaders of Place based organisations. The aim of this committee is to bring place-based organisations together to focus on key pieces of work to improve patient care. Underneath

this committee sits, population focussed programmes e.g. long-term conditions. These governance arrangements only relate to NHS money and there is no decision-making power within any of these structures. They can make recommendations; however, individual organisational sovereignty means that decision making sits within each individual organisation. At times, when money or resource becomes more challenging, we were able to observe leaders focussing on their own organisational priorities rather than overarching Place priorities. This led to providers not being willing to carry the financial burden for Place organisations and reduce their contribution to specific programmes of work.

> *Really, realistically. And today, the reason I've brought [programme of work] in there today was, because we've been paying for that, [organisation] have been paying for that by ourselves. There's only so much…so far that I can do that and I can't, you know, my organisation has tough decisions to make to deliver a financial balance and I can't make the…I can't put in an additional [amount of money] by making nurses redundant. It's just not going to happen…And so, like, well, I'm sure you heard, but I was really clear that I wasn't coming to [partnership meeting] for more money, I was just explaining to you what was happening. [Programme name] is spoken about by everybody, about what a fantastic project it is, but nobody wanted to put their hands in their pockets, so we are where we are. (P002yt)*

In Site B there are no formal Place based committees that support integration beyond those that are statutorily required such as the Health and Wellbeing Board. There are two longstanding Joint Commissioning Committees, bringing together Local Authority and NHS commissioners to commission joint services using the Better Care Fund and Section 75 agreements. As discussed above, this site had decided to organise its commissioning functions around programmes of work rather than geographically around Places. The programmes each had a committee, bringing together relevant providers and commissioners to make recommendations as to how services should be developed, with staff responsible for the more technical functions of commissioning – including contracting etc – 'wrapped around' each programme. Discussions were under way as to the role of Place within the system, but currently there are no specific commissioning or management structures in place. In Site C, integrated working was already happening locally in several different clinical areas (e.g. mental health) as well as pockets of innovation within particular towns and districts. The Place level structures that had been established provided a forum in which local successes can be shared and supported, via an integrated care board, which includes representatives from ICB, Places and providers. However, when management costs were reduced Place based structures were hollowed out, reducing the perceived effectiveness of the local integrated care board. Respondents told us that integrated care that was being delivered locally prior to ICB formation has continued to be delivered, and that there has been increased communication and sharing between local commissioners and providers since the ICB was formed. There are forums through which those responsible for local delivery have a voice in shaping emergent strategy, but these forums have not yet moved beyond that 'emergent' phase, with little effective attention thus far to outcomes across the ICB.

Looking across the three sites, Site A has paid most attention to developing commissioning structures at Place level, driven by their early decision to delegate commissioning responsibilities to this level. The decision in Site B to arrange commissioning around programmes of work rather than geographically led to a structure by which commissioning support was aligned with programme committees. The committees themselves had no commissioning powers, rather they made recommendations which were then agreed by ICB strategy and finance committees before being enacted by centralised commissioners. There

were limited formal structures at place level, beyond longstanding joint commissioning arrangements with Local Authorities. Internal discussions about the meaning and role of Place were ongoing. In Site C, the reduction in managerial costs had led to the withdrawal of all but one or two commissioning managers from Place level, with a corresponding reliance upon provider alliances to sub-contract and take over operational commissioning responsibilities.

> *The interesting bit at the local level and the hyperlocal level is the extent to which that would be a function of ICBs. And I think the short answer is that it won't be because the ICBs won't have the capacity to do it. The ICB becomes, you know, a strategic commissioner of neighbourhood health… the ICB understands its population, its needs, its inequalities, its outcomes, variation of those sorts of things and commissions a provider to do something about it. And then the ICB would assess the extent to which that provider has done something about it or not. What that…is predicated on is that…the provider is able to operate as either a prime provider that effectively subcontracts or commissions, subcontracts other providers to do a whole pathway piece or I'm talking about a provider that is actually potentially a provider collaborative or some sort of consortium…And if the ICB isn't there to be that operational commissioner to say, right, we want to commission primary care to do this, we want the voluntary sector to do that…you know, the ICBs just won't be able to…they'd never be able to keep tracks on it…So, it is into that bit of finding a provider or providers as a collective, here's some money to go and do some stuff but we want you to achieve this shift in outcomes. (P0039hs)*

Research questions four and five

Our next two research questions focused upon the mechanisms by which local Places were commissioning services:

Research Question Four: How can different contractual arrangements contribute to the delivery of integrated care within Places, and what oversight arrangements are required?

Research Question Five: How do different approaches to primary, community, mental health and social care service commissioning, contracting and support affect the delivery of integrated care within neighbourhoods?

However, across our case study sites we did not find any evidence of significant changes in commissioning approaches since the creation of ICBs, nor did we find any new innovative contractual arrangements being used to support integration. We found that in two of our three sites the concentration of formal commissioning responsibilities at ICB level meant that local service delivery tended to roll forward based upon historical arrangements. Although there were some pockets of new activity around particular local services, contractual mechanisms such as Section 75 agreements (used to pool budgets between local authorities and the NHS) and the Better Care Fund monies were the main contractual or funding arrangements which were utilised locally to help integrate organisations or pool organisational monies into programmes of work.

> *The third bit in terms of contracting because there are some things that we do jointly with the local authority where we either do it literally jointly where we've got people in the same room and at the same time, or some of it is delegated to one or the other*

organisations collectively our behalf. So, in that, there's things like mental health, Section 117, caseload, quite a bit of the voluntary sector, the stuff that goes through the Better Care Fund is done jointly where we've got money for discharge capacity, supporting hospital discharge, that sort of stuff, the care placements that might be coming out of NHS discharge pounds but actually it's commissioned by the local authority on our collective behalf. And they manage that. (P0039hs)

In the absence of new contractual or other approaches, we asked respondent to reflect upon the things which they felt were either helping or hindering local approaches to developing integrated neighbourhood services.

Helpful factors for local integration

A clear focus

Local commissioners at both System and Place level spoke about the importance of having a concrete 'thing' to work on together to enable stakeholders to meaningfully work together. Each individual and organisation naturally work to their own organisational demands and therefore it is useful to be able to find a balance across both organisational and collaborative ways of working.

…never all be on the same page because they will come from their own independent business perspective and sustaining that. So, for me, it's around supporting them to sustain their independent business model but equally bringing them round to the table and collaborating in a way that perhaps they've never done before. (P011ih)

One commissioner suggested that the tendency within the health system to blame other parts of this system when things do not work well made collaborative working more challenging. To support joint working, you need to be able to know what the benefits will be for patients.

So, there is a culture of blame within I would say, system work, secondary care and some of this, this is not a secret, this happens all over the country. So, General Practice will blame secondary care for pushing work their way, secondary care will blame primary care for pushing more referrals that they don't feel is necessary and could have been managed better in primary care. Then you've got that shift around community and prevention that sits on the periphery that sometimes the challenge is around you don't have enough district nurses; they're not meeting our needs. So, it's just some examples really, of for me, that huge cultural shift that I feel is a real challenge to get everyone in the room and working together for the benefit of the patients. Yes, it's the, what's in it for me, that's what I try to always go back to is if you bring people around a table, there has to be an element of what's in it for me. So, how is this going to make my life easier by collaborating with you and what do we both get from each other for the benefit of the people who we're essentially providing services to. But it's not always easy to do that. (P001ih)

Commissioners spoke of their role of being a 'cog' within the System, connecting different organisations and System partners together, to focus on specific pieces of work.

So, although I'm involved in the Place-based work, developing neighbourhoods, I'm a cog in that, if you like. So, the work around the [local integration initiative] basically is when you want…you need to get people…if you want to create a team, you need to give them something to do, don't you. So, I suppose for me, the [local integration

initiative] gives them something to do and a purpose to get them working together. (P0013nq)

One significant aspect of the work of local commissioners was to perform the integrator role; this involves bringing System partners together but also facilitating on-going organisational development to ensure that organisations are willing to continue to work together over time. This role is constant and required to support integrated ways of working locally.

> *So we do work with relationships, whether it's our providers or our ICB, so we do that on an individual basis and collective basis. Obviously, we have the joint meetings, Place Board et cetera, where we obviously come together. However, I would say there is more needed. If we've got a clear role and remit, whether it's dictated to or decided, and being clear around then who needs to be around in the table. And provide then that opportunity for OD is really important, to be able to facilitate that. And time and space to be able to do that as well is also important. So, we do do bits and pieces but probably not enough as we could or should do. (P0021px)*

One commissioner suggested that although there were some formal mechanisms to encourage local partnership working; to really bring about change in this area, more formal steps were required to bridge funding opportunities between the NHS and local authorities. They argued that this was crucial for the success of national policy goals of local neighbourhood health services.

> *I think more formal integration between health and social care, between the local authorities and the NHS. So, we've got mechanisms that do that, things like the better care fund and lots of joint budgets and joint teams and that kind of thing. But I think doing more co-commissioning, again we're going to need to be quite radical, I suspect about how we try and do some of these things in the future. But having much more joint commissioning, more joined up partnership working on a formal basis between councils and the ICB and Place will really help. That will help develop that neighbourhood health service model and that kind of thing. So, that would probably be my one main tip, I think for future change. (P0019hu)*

Good data management and linked data

Commissioners spoke about the importance of good data management and mechanisms of linking data between organisations. Data was described as a useful tool to help understand population need collectively and individually. In site A, they spoke of their data systems being advanced due to the linkages across different local organisations. There was hope that good quality data would underpin local joint approaches to help address specific health needs.

> *Well, underneath public health, social care and the NHS, we are linking an individual's data. So, if you…if you have been going to your GP lots and then you go to…and you've been seeing your social care worker as well, and then you turn up in A&E, we link it all together, so… But it's all anonymised, so we can't see it for an individual, but it's linked in there, so we can ask really intelligent questions…we keep building it, we've got [charity name] data in there, we've got some housing data in there as well. So, we've got the ability in the future to ask some really good questions of the data that we can't answer currently…Which in terms of integrating a response and…it's got a huge amount of potential. (P0014et)*

Clear role and remit

Interviewees in Site A told us that clear roles and decision-making responsibilities were vital in the development of neighbourhood services:

So I think that where we are is there's pretty good shared understanding that there are must dos and the role… I mean, I would see the role of Place ICS as absolutely critical in delivering the whole Neighbourhood health agenda and including integrated services and systems. I can't see how it wouldn't be absolutely central, the ICS role of Place. I think what the trick is, is how we negotiate scope at every level. So, for example, in phase one of the Neighbourhood health work, we've had conversations about clarity of scope and being really clear about clarity of scope. And then actually, in later phases, actually looking to include more elements of different things, but not at the beginning.(P0012nd).

In Site B, by contrast, commissioning was organised around programmes of work (e.g. urgent care, community transformation). The advantage of this way of working was that it brought together service providers from all sectors, allowing them to develop a collective approach. One respondent suggested that not having actual spending powers was helpful:

So, in a way, I think not being a subcommittee of the board in [programmes] is really useful because you're there to do that alignment piece rather than to fight over resource.(P0018ip)

However, this approach requires there to then be a streamlined approach so that once a recommendation had been made the decision-making structures within the ICB were able to authorise relevant changes. Without this the programme group may lose momentum.

Good long-term relationships

Partnership working often takes time to develop and is underpinned by good relationships. In Site A, they had been working across the same geographical footprints, with the same organisations for many years which supported opportunities of local collaboration. The ethos of the ICB was focussed on partnership working across the different ICS spatial levels, encouraging involvement from all sectors at different boards and committees. In site C, they spoke about one of the strengths within their local Place was that they had a good history of working together which meant that they could have honest conversations to find System solutions when they were faced with local challenges.

And actually, in [Place name], a real strength of… in all of the Places, we've got really long and well-established history of joint working across system partners, so I think we're in a good place. It's not a…we're not in a place of conflict. And even where we do have financial disagreements and the usual sort of transactional punch-ups that you might normally expect in the course of business, we've got established relationships that mean you can have the grownup conversations and work the solution, sort of, respect where different parts in the system might be coming from, what's driving their positions. Then, right, okay, and we get something that's a sustainable solution. So, we've got that. (P0039hs)

Commissioning partners from Site B commented that when trying to establish collaborative ways of working, organisational development is important to help build understanding and local relationships.

So, within the [Place name] Together partnership with external organisational development, we spent a lot of time together, we built those relationships, we developed our model together. We did work around [programme of work name] so I was a GP for a day and that was interesting. Those sorts of things. Whereas in [Place name], we've got none of it, so there's been no investment jointly for organisational development. There's been no collective [name of work programme], et cetera, and

getting to understand the pressures of community care versus primary care to acute care, they all come from different perspectives. So that's really important. (P0021px)

Factors that hindered local integration

Loss of clinical voice

A significant change when ICBs replaced CCGs was the changes to the membership of specific committees and decision-making boards. CCGs had been established as membership organisations with a strong GP voice. One of their many purposes was to ensure that the clinical voice and insight was part of the local commissioning process. Whilst ICBs did initially have GP representation at Board level, clinical involvement in the day-to-day work of ICBs was not mandated. GP involvement with commissioning committees was therefore variable across the three case study sites and more diluted across larger geographical areas. One interviewee commented that the current System structure had negatively impacted on the clinical voice, with GPs involvement with wider System work reducing.

And one thing I've not really touched on is our primary care…particularly the GP colleagues. And actually, we've got some real forward-thinking clinicians in [Place name]…and a few years ago some of them were really putting themselves forward as…with some really good ideas. We got a lot of…it felt like we got a lot of real things we could grow. And I think a lot of them have been just subsumed into the day job. So, what I don't want to do is lose that…I mean, that's part of what CCGs were about, I guess, but lose that clinical leadership in GPs. And I do wonder why people like [GP name] who was just…had so many good ideas, why he's gone quiet. So, I think it's…if I could change one thing, it's making sure that clinical leaders have got a good voice. Particularly primary care. (P0014et)

As set out in the 10 Year Health Plan, GPs will be important stakeholders in the delivery of Neighbourhood Health Services. It will therefore be necessary for Systems to develop ways of engaging their local clinicians, including GPs.

Service pressures

Working collaboratively or in an integrated way was accepted locally, by the majority as a positive step forward. However, developing such ways of working and bringing about change is time consuming and is undertaken in addition to the existing work demands and priorities that local organisations face. Juggling increasing daily demands often meant that there was little time for people to meaningfully engage in partnership working arrangements.

They're so busy, they are just absolutely run ragged with the job, I think I was the director of primary care previously for ten years and the growth and activity in primary care, […] it was something like twelve per cent, we've seen a massive growth in primary care activity, appointments and it just makes it even more difficult to be able to do the job that people want to do, especially if it's extra-curricular, if you like…I very much saw the ARRS roles as primary care workforce in addition to primary care. It's so much more than that, it's that link with the wider system. So, I think that's a really big opportunity for us to expand that model but I genuinely think we're just so busy on the ground, operationally, they're trying to do the job, they're treating patients, aren't they. So, there is not a lot of wiggle room, there is too much to do. (P013nq)

There was a lack of capacity not only in workforce but also management and operational structures that impacted on how people worked together. Practical restrictions, such as time, funding and ways of working often led to individuals retreating to their individual organisational practices as they did not have the bandwidth to understand how to do things differently.

> *But actually, there isn't the capacity, there isn't the organisational structure, there isn't the management and wider understanding of most of my colleagues as general practitioners, even as leaders, to really understand what is being asked for, the implications of the policies and the strategy to be involved in that higher level discussion. What they often resort to is very much, kind of, their individual perspectives or their, sort of, tribal perspective on what the issues and what the problems are. It's a bit of a…you know, I don't think it's unfair for me to criticise my own kind, I am, by virtue of it, within that group. But I see they have…most of them have a very narrowminded view. And for the right reasons. There isn't the culture, there isn't the headspace, there isn't the funding to allow…to understand the wider aspects of what we're asking for. (P0022im)*

This is particularly important, as the reduction in managerial costs imposed on ICBs (NHS England 2025) will further limit the availability of managerial support at a local level.

Multi-level decision making processes

As discussed in the introduction, ICBs are considerably larger than previous commissioning organisations. If decision-making remains concentrated at System level, local Places or programmes of work can make recommendations but must await decisions made by the higher level of the System. Where decision making is devolved, there remain oversight procedures which may feel onerous:

> *It feels harder, and it feels harder because most decisions can be second guessed by the level of [the ICB] that wasn't there before. So if I want to rejig my team in order to, I don't know, as I said earlier, focus a bit more on planning, I almost certainly will go through loads of hoops that were never there before. Can you justify that, why do you want to do that? We've done lots of internal justification… It feels a bit overbearing, so I think that is the heart of it, and you're having to align to another layer. (0001jd)*

Collaborative working was valued across our sites. However, respondents recognised that at times difficult decisions needed to be made which would not necessarily please everyone:

> *The problem is, everybody wants to be friends. The difficult decision stuff is genuinely very difficult. And I think sometimes, as much as people don't want it, someone has to make a decision. And I think it's probably building the culture that allows to somebody say, well, you're doing it this way. There are times when you win, there are times when you're going to lose and you just have to…because sometimes you end up doing a merry dance or you get indecision because it's too difficult and we skirt around the edges because we don't want to upset anybody, we don't want to put any of the Places out and, oh, that's difficult for them. So, I do think at some point, we just need to strengthen…we've gone through it, everyone's said their bit, we've all thought about it, we've got the consequences, we've got the risks and we've got the benefits, this is what we're doing, we all need to sign up to this and then deliver it. (P007he)*

It is therefore important to have a structure in which such ultimate decision making can be performed, with clarity as to where the responsibility sits.

Individual organisational sovereignty

ICBs were created to support collaboration across their geographical footprint. However, individual organisational sovereignty and responsibilities were left intact, with providers regulated separately and required to meet financial performance targets. This can be counterproductive for collaboration as these quotes suggest.

Yeah. I mean, it does seem that some individual targets just get in the way and people then revert to worrying about their own target more than anybody else's. So, I think if you could somehow take that away and just have that focused in on the person and their whole experience. And then, you know, that's probably a Utopian world I'm describing, but in that world where your individual organisational performance didn't matter, what mattered was collective, integrated performance, that will be much stronger. Difficult to achieve in reality, isn't it, because you have to have organisations, you can't just have one big thing. So, inevitably, people worry about their own bit of it; that's human nature. (P0028rg)

Yeah. It's a bit like, you know, it's kind of, we have the Better Care Fund and we've got [Programme name] and all this thing and we have ICBs. And yet there's a tribalism that…you know, it's a bit like the UN I guess when you're in…all in that UN, everyone says how great, marvellous and how aspirational everyone is. And then you go off to your own little country or tribe and you have a slightly somewhat different view. And the practicalities of trying to separate the practicalities or the politics from the aspirational bits of it. (P022im)

Furthermore, money is not necessarily directed towards integration or integrated ways of working. Instead, money is allocated to individual organisations. This mechanism of allocation often means that the money is seen to be owned by each organisation for them to use as deemed fit, which in the majority of cases means that financial flows stay within organisations, limiting the scope of the integration agenda.

And so, each individual is impacted by their own financial flows because money just goes to them, it doesn't go to the neighbourhood or the integrated whatever. Whereas if it was all, sort of, pooled and seen as one thing, then I think it would open different opportunities and people would work…would naturally work differently. So, I think the finance bit needs to enable integration and I don't think it does at the moment, I think it's an inhibitor for it. (p008iv)

Integrated ways of working bring together organisations that work beyond the NHS and their financial models. How an organisation is funded, or underfunded, impacts on how organisations can work together. The differences between health and social care funding and responsibility were perceived to undermine collaborative working, with disjointed funding negatively impacting patient experiences and local integration.

Oddly, it would be to have greater clarity on the sustainability of the domiciliary care sector and that's the social care sector. If I think about the ability on a key sector to collaborate when they're faced with the financial challenges that they're faced with…I don't, I really don't know how they do it. Because there's endless pressure, you know, to increase flow through the hospital by offering more domiciliary care packages and yet it's not affordable. And for them to take part as, you know, meaningful partners what they need back is residents who are more resilient. And oddly that's also the local authority's responsibility, it's a different part of the local authority. And prevention services just don't exist. So, I suppose my overall priorities are…if I could have money and if I could effect change, it would be money to put social care on a more sustainable footing and then money for prevention and sustainable communities. And I think that would make everyone else's ability to integrate much easier because there's organisations there that have the capacity to integrate. (P010xa)

One respondent suggested that allocation of costs to individual organisations often undermines local relationships and goes against the principles underlying the Neighbourhood health services agenda.

But I suppose, what frustrates me is that, I mean, like the issue that I had raised yesterday about trying to discharge a patient, and a delay because of consumables. It's like, that shouldn't be happening, if it's a neighbourhood, you know, if we're taking a neighbourhood approach, and a provider collaborative approach, why are we quibbling about a few pounds for a patient that's got nursing care needs, needs to be in a nursing home, they shouldn't be sat in a hospital bed. And it's how do we, you know, there's a lot of unpicking that we're going to have to do with current practice, as well as doing this building up, this programme of work. I think there will be challenges in terms of, from some part, obviously, quite a few parts of the system, we've talked around the concept of, you know, integrated care teams before. It stalled, either because of finance, or sort of, changes in policy, and finance arrangements, and things like that. (P0025sg)

In addition, the requirement for each organisation to meet its regulatory and financial duties was felt to induce a degree of risk aversion. This needed to be tackled if joined up working was to be better enabled:

And so we don't have a joined up risk management approach. That actually is a real fundamental blocker to us working together. If you design it from scratch you would look at collective risk management, relative risks and benefits and you would come up with a system that interfaces between the two. Because we've left risk separate we've therefore disjointed the system. And you close a waiting list and it's okay we're safe. But we're not. The patient is still the patient with the same need, but they're now held in an environment where the skillsets to deal with that are not present. (P016as)

Risk aversion signals the need for time within collaborative agreements for building relationships and trust. One participant in Site C felt that they did have the contractual tools required to enable greater interorganisational collaboration, but he did not feel the partners would be ready to commit to it under the contemporary conditions of change and uncertainty.

The problem is, at the moment, because it is emergent to have that sort of conversation about collaborative agreements and then where that might go in terms of contracts, they run to the hills, being blunt. So, I'm keeping that one in the wings for now. But I think that's where we'll need to get to, at some point we'll have to get to a point where they're tied in because if the ICB hasn't got the capacity to do that operational commissioning and very localised management and contractual oversight and things, someone else will have to do it. (P0039hs)

The language of commissioning

The Health and Care Act 2022 and associated guidance emphasised collaboration and collective decision making, with little or no mention of commissioning functions. Within our sites their response was to cease using the language of commissioning. One Place lead suggested that they had removed the word commissioner from all local job titles because it had negative connotations often associated with contracts which was counterproductive for the integration agenda.

Because I think historically it had a whole set of baggage attached to it about what a commissioner's supposed to do which is tell us what to do and we disagree and don't like it.. (P001jd)

It was acknowledged by the same leader that commissioning functions still had to exist, but the move away from the language of commissioning was felt to be important.

> *…So you still need all those bits, you still need to design services, you still need to understand the population need, you still need to let the money flow through the system, you still need to do monitoring and checking you've delivered, but there's a really different way of doing it, and if you use the same language you end up doing it the same way.((P001jd)*

Others felt differently, with this leader from another site suggesting the losing the language of commissioning had led to confusion and lack of progress.

> *And because of that, and because I think CCGs had taken some things too far in terms of the kind of assurance role that they thought they were playing, commissioning kind of disappeared as something that people talked about. It was almost like a word that was banned, like, you were no longer really allowed to speak about it. And I think that was unfortunate because I think what it meant is, I think, you know like I said to you, I think this system was maybe for 18 months slightly a little bit lost in the wilderness. I think it was a little bit lost in the wilderness 'cause we weren't really allowed to talk about…that was one of the contributing factors. We also weren't really allowed to talk about commissioning. (p009yx)*

Towards the end of our data collection, period, the national narrative on commissioning changed, with the publication of the ICB Model Blueprint (NHS England 2025), which explicitly positions ICBs as 'strategic commissioners' and suggests a narrower focus on commissioning services from a range of providers. The 10 Year Health Plan reiterates this, advocating the removal of Provider representatives from ICBs. It remains to be seen whether this change in national narrative and focus will support a more effective approach to service design and delivery. Some of our respondents welcomed the change, arguing that it would bring back much needed clarity. Others argued that it would risk losing the progress which had been made in developing new ways of working together across the commissioning/provider divide.

Case study Summary: to what extent are the factors identified as being important for the commissioning of integrated services present?

Table 5 sets out a brief overview of the extent to which we found the factors identified in our literature review within our case study sites:

Table 5: Presence/absence of necessary commissioning elements

Factors needed to support commissioning of integrated services	Findings from case study sites
Clarity over roles and decision making	Present where formal delegation of commissioning responsibilities has taken place, not present otherwise. A degree of confusion over who is responsible for what in some areas and multiple layers of decision-making present in most areas
Managers with skills and local insight to support and broker relationships	Managerial support good and valued, but concerns over cuts to management budgets. Areas which had worked together in the past at a considerable advantage
Allocated budget, and incentives to support collaboration	One out of three sites had formally delegated funding. In other sites financial decision making remains at ICB level. Individual organisational incentives to maintain financial balance remain problematic for collaboration
Ability to set appropriate local goals	Lack of clarity over responsibility for local decision making makes goal-setting complex. Perception that local decisions could be second-guessed at higher levels, with associated loss of momentum.
Skilled leadership	Good leaders acknowledged, but concern over loss of clinical leadership in some areas, with service pressures identified as preventing engagement
Appropriate geographical coverage to facilitate local relationships and engagement	Sites where Places have worked together previously and are co-terminus with local authorities see Place as the natural level at which integrated working can be supported. Where Places are not functioning, the ability to link with local authorities is more limited.
Good understanding of local population needs and capacities and capabilities of local providers	Recognition of the importance of these standard commissioning functions, but concern that they have been somewhat hampered by the loss of the language of commissioning. Concern over managerial budget cuts and loss of local insight.
Mechanisms for monitoring services and outcomes	

Discussion

Summary of findings

Overall, we found that, within our case study sites, the factors identified from the literature as being necessary for the effective commissioning of integrated services were only present to a limited extent. The most notable finding was that the clarity around roles, responsibilities and decision making which the literature highlights as a foundational requirement for collaboration across organisational boundaries to deliver more integrated services was only present in the site which had formally delegated funding and decision-making to Place level. Whilst all our sites were working hard to design and deliver new approaches to service delivery, where formal delegation of responsibilities had not occurred, committees could only make recommendations, and any proposed changes had to be signed off by higher level committees. This tends to lead to organisations defaulting to a position which prioritises individual organisational priorities because these are the ones over which they have authority. Pooling sovereignty to make decisions which may be problematic for individual organisations is difficult where the collaborative forum does not have decision-making powers (Michgelsen, Glimmerveen et al. 2022). Skilled managers were present and valued,

but there was concern over the requirement for ICBs to significantly reduce managerial costs. Supporting collaboration and collective decision-making is labour-intensive and requires investment in relationship building (Lewis, Checkland et al. 2021); the impact of reducing the number of managers employed is already being felt in our case study sites, with respondents describing a 'hollowing out' of managerial functions.

The need for good relationships also highlights the importance of size and geography. We found that effective collaboration requires a 'human scale', in which individuals know and trust one another. Those areas where local geographies had been stable for a number of years were at an advantage, as individuals in different sectors had built relationships over time, supporting their ability to collaborate. Co-terminosity between local authorities and health services, although not a panacea, can be helpful. The site which had decided to organise service development by programme rather than by geography subsequently experienced some difficulties in articulating the role and remit of Place in their System. This could be problematic, particularly when service development required liaison across geographical areas with Local Authorities and other locally-based service providers, and where service integration required an approach which cut across programme remits. Finally, respondents acknowledged the importance of traditional commissioning activities such as needs assessment and monitoring of service outcomes. However, they told us that, in the early days following the Health and Care Act 2022, there had been a deliberate policy to downplay the role of commissioning, including changing job titles and managerial language. Some felt that this had been necessary to support new ways of working more collaboratively, but others told us that it had gone too far and the change in language had led to a loss of focus and loss of experienced commissioning managers.

In summary, we found that following the Health and Care Act 2022 there was a loss of focus on the tasks of commissioning and some confusion as to how service development and management functions should be organised. Delegation of decision-making and funding to Place level in one area provided clarity but also introduced some new constraints in the form of additional layers of oversight. In other areas decision-making was retained at ICB level, constraining the ability of local Places to make meaningful changes to their local services. The lesson from the literature on developing more integrated services is that clear locally agreed goals and decision-making processes are vital; our study suggests that that clarity is currently lacking.

Implications for policy in the light of the 10 Year Health Plan

The 10 Year Health Plan (Department of Health and Social Care 2025) places considerable emphasis on the development of more integrated neighbourhood services to deliver an anticipated shift from a health service dominated by hospital services to one in which people are able to obtain the care that they need nearer home and in their communities. It is argued that such a shift will release resources and improve both experiences and outcomes of care. Provisions in the Plan which are relevant to the delivery of integrated services via a new 'Neighbourhood Health Service' include:

- Better access to primary care services via:
    - Training more GPs and other staff trained for roles in the community
    - Reducing administrative work in general practice via the use of AI scribes
    - Increased digital access to appointments and information via the NHS app

- A shift to more patients receiving care from integrated teams within neighbourhoods, delivering more care outside hospital, with an increased use of care plans for patients with complex needs
- The use of data and genomic information to deliver personalised predictions of future health challenges, allowing the provision of more preventative care in the community
- An increased use of personal health budgets
- The development of Neighbourhood Health Centres delivering a wide range of services in the community
- An increased role for community pharmacies in delivering chronic disease management, vaccinations and screening services

The mechanisms suggested for delivering these benefits include:

- A strategic commissioning role for ICBs, commissioning neighbourhood services from a range of competing providers
- Two new forms of contract, one covering single neighbourhoods, one covering multiple neighbourhoods
- A shift in resources from hospitals to the community
- New payment approaches, including new tariffs for community and mental health services and the trial of a 'year of care' budget for some multi-neighbourhood providers
- The development of Neighbourhood Health Plans by Health and Wellbeing Boards
- The strengthening of Foundation Trusts, with the best eligible to become Integrated Health Organisations, managing a population budget

In addition, following the publication of the Plan, a National Neighbourhood Health Implementation Programme (NNHIP) has been announced. Places within ICB footprints have been invited to submit bids to join the programme, with 43 now approved (The Integrator: 141 Ten-Year Plan 'test beds' | Expert Briefing | Health Service Journal) Places that wish to take part must establish 'Place teams' comprising representatives of all community-based services providers (including the Voluntary Sector), Local Authorities and patients. Teams will be supported by national 'coaches' to develop new approaches to delivering care for people with complex needs, and encouraged to work together with teams from other areas to develop and test new ways of commissioning services, including the use of new contracts and payment models. The programme is using a rapid learning approach and West Midlands Strategy Unit will provide support with the analysis and evaluation at sites – though the detail of this has still to be finalised. Alongside this programme, it has been announced that there will be a negotiation of a new national General Medical Services contract for general practices (https://www.pulsetoday.co.uk/news/breaking-news/streeting-reconfirms-commitment-to-new-gp-contract-and-partnership-model/).

Our study suggests a number of factors which could usefully be considered in the implementation of these plans:

- **Greater clarity is required around responsibilities and decision-making powers within ICBs below Board level**. The evidence suggests that most decision-making about high volume low complexity care within neighbourhoods needs to happen over a geographical scale within which those responsible can develop appropriate insight into the capabilities and capacities of the full range of local providers, alongside the necessary trust and good relationships.

- **Clarification of the appropriate geographical scale over which particular types of services should be commissioned and overseen is urgently required.** Lack of such guidance coupled with stringent financial targets has driven a risk-averse approach, with limited or no discretion at local level in many areas. This has led to complicated decision-making structures and loss of skilled staff who used to be the 'glue' supporting collaborative activity. Lack of such guidance in one of our sites let to the establishment of a commissioning structure which was not well adapted to the subsequent focus on neighbourhoods

- The Plan does not address explicitly the nature of commissioning arrangements for Neighbourhood-based services; **our study suggests that this responsibility would be most effectively carried out at Place level,** which is a geographical scale within which it is possible to develop the requisite understanding of population need and for the relevant relationships to be developed and collaborations to be established with local authorities and other place-based entities. It is also a scale over which it is possible to undertake the public engagement required to ensure that services meet population aspirations as well as needs.

- It is suggested in the 10 Year Health Plan that **a large-scale provider could act as local commissioner, presumably using a prime (or lead)-provider contract model.** It may be that this is what is intended for multi-neighbourhood contracts. The evidence relating to prime/lead-provider contracts in the NHS and other settings suggests that **there are some potential benefits but significant concerns about costs, relationships, and governance accountability. There is little to suggest it facilitates improvements in inter-organisational coordination or integration** (Sanderson, Allen et al. 2018). A study of attempts within the NHS to establish such contracts highlighted the significant amount of pre-contractual commissioning activity required, suggesting that independent commissioners are still required, even if responsibility for service development within agreed parameters is allocated to lead providers. There was also a need for extensive pre-contractual legal advice. Incentivising collaborative activity via new payment approaches provided difficult in practice, and collaboration could be derailed by pre-existing poor inter-organisational relationships and by financial pressures on individual organisations within a collaborating group (Sanderson, Allen et al. 2019).

- The 10 Year Health Plan suggests the development of new forms of pooled budget, whereby local providers could be allocated a 'Year of Care' budget to provide care either for a geographical population or a more limited defined population (eg people living with diabetes). At larger scales large providers could hold an entire budget for a Place or similar geographical population, becoming 'Integrated Health Organisations'. **Our study suggests that such an approach to pooling budgets may usefully address issues with current budget pooling approaches,** in which budgets remain with individual providers. Under current arrangements respondents told us that meaningful joint decision-making was hampered by the fact that ownership of budgets remained with individual organisations. **However, a large scale pooled budget would require strong governance and accountability mechanisms, with appropriate mechanisms to support priority setting.**

- **Effective inter-organisational integration and collaboration requires investment in managerial capacity and skills** in order to navigate boundaries, build and maintain relationships and sustain collective-decision making processes. **An effective**

independent oversight function, with the capability to act as an honest broker between organisations working together and provide appropriate performance management **is also required**.

The delivery of the aspirations set out in the 10 Year Health Plan will be set out in guidance and plans over the next few months. Our study suggests that the following issues should be considered:

- **Place is important.** The focus of the 10 year Plan is on delivery at Neighbourhood level; our study suggests that high quality delivery in Neighbourhoods requires appropriate commissioning structures at Place level.

- **Be clear as to the language used.** Respondents told us that an unhelpful focus in the early days of ICS development on 'not doing commissioning' led to a loss of focus and loss of expertise as commissioning roles were de-prioritised. If contracts are to be the main means by which services are procured and delivered, a return to clear language around commissioning is necessary.

- Whilst there are good reasons to allow local areas to develop the design Neighbourhood Health Services in ways which meet local needs, operational guidance setting out requirements for local decision-making and governance structures to oversee that development is needed. **We suggest that strong commissioning structures are required in local Places**; allowing local areas to design their own decision-making structures has led to confusion and risk aversion, with decision making retained centrally within Systems. This does not facilitate local innovation.

- Even if significant elements of commissioning responsibilities are handed over to large scale providers, **independent commissioning managers will still be required** in order to oversee the large-scale contracts, support collaboration and hold providers to account for their performance.

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