**Lead Commissioning – a brief introduction**

1. Lead commissioning is an arrangement via which statutory bodies as currently configured contract for the commissioning of services for a defined population. Contracting in this way allows Partnerships to pool their respective resources for the population of interest, into a single integrated budget for the commissioning of services. In many cases staff also transfer from one body to another to allow integrated service provision for the target population, which may be based on age (such as older people), or care groups. Lead commissioning is used elsewhere – Torbay and North East Lincolnshire, for example – with some reported success in terms of better outcomes for services users and more efficient use of resources. Further details on Torbay and North East Lincolnshire are provided below.

2. In effect, lead commissioning enables integration across statutory bodies in response to the needs of targeted population groups – partners can integrate in response to older people’s requirements without embarking on wholesale structural change, for example. Although some staff may move from one organisation to the other under the new commissioning arrangement, this is a level of reorganisation in which form follows function. So, for example, if adult social care services were commissioned from the health board by the local authority, some adult social care staff might move from local authority employment to health board employment. The key point is that it is the service to be supported, and its clinical/care outcomes, that is the prime factor in determining who goes where, rather than reorganisation taking the lead in the hope that better integration will follow.

3. In Scotland, under a lead commissioning arrangement, local authorities could for example commission adult social care from health boards; health boards could commission health improvement from local government; and health and social care budgets could be delegated to the Community Health Partnership (CHP), which would be responsible for the joint resource.

**Plans in Highland**

4. In Highland, plans are under development for the local authority to commission adult social care from the health board, and for children’s services to be commissioned by the NHS from the local authority.

5. Current legislation (the Community Care and Health (Scotland) Act 2002) provides permission for these arrangements. We are working with colleagues in Highland to establish draft governance arrangements and clarify specific questions
relating to employment of Mental Health officers (which is required by statute to be within the local authority) and provision of health services for “young” children (which falls within the definition of maternity services and is a statutory responsibility of the health board). This guidance will be available to other partnerships in Scotland who may wish to put in place similar arrangements in future.

6. Highland are building on work towards better integration that has taken place over the last several years, including the development, initially locally and subsequently nationally, of the Integrated Resource Framework, which provides a model for integration of resources (money and use of people’s time). Highland is one of the four IRF test sites – the others are Lothian, Tayside and Ayrshire and Arran. This development also builds on their experience as a Getting It Right For Every Child (GIRFEC) pathfinder site. The move is also coherent with the principles for pooling resource around population requirements that underpin the Change Fund for older people’s services.

Evidence for lead commissioning from England

7. SG officials have visited Torbay Care Trust and North East Lincolnshire Care Trust Plus, which have both introduced lead commissioning arrangements and report evidence of improvement in services as a result.

Torbay Care Trust

8. Torbay Care Trust was established in October 2005 by Torbay PCT (Primary Care Trust) and the co-terminous Torbay Council. The PCT was dis-established, and the Care Trust established with adult social care services transferred from the local authority.

9. The Care Trust has integrated the following activities within a single organisation:
   - Commissioning of healthcare (primary, community, acute and tertiary) and adult social care; and
   - Provision of community healthcare and adult social care.

10. This diagram illustrates the integrated arrangements in Torbay; the red dotted line represents the flow of resources and the blue solid line represents accountability:

"Figure 1: Torbay Care Trust"
11. Governance of the Care Trust is provided by the Care Trust Board, membership of which includes two Councillors nominated by the local authority. Attendance by the latter is required for the Board to be quorate.

12. Key learning points from the experience of planning and delivering integrated care across the Care Trust are reported by senior managers in Torbay around the following broad themes:

- **Local solutions**: at the time the reorganisation took place, local authority social care services were assessed as performing poorly, providing a good opportunity to capitalise on the need for change;
- **Leadership**: success in Torbay is repeatedly reported as the product of exceptionally strong, consistent leadership and the ongoing strength of the relationship between senior managers at the Care Trust and the sole local acute hospital, which is run as a separate NHS Foundation Trust;
- **Shared culture and objectives**: the symbolic significance of transferring all staff – NHS and Council – to the new Care Trust was important, helping to reassure social care staff that the reorganisation was not simply a takeover of social services by the NHS;
- **Effective and appropriate financial arrangements**: the Care Trust was originally established as a pooled NHS and local authority fund. However, the arrangement has proved confusing – with the partners sometimes operating as equal partners, and sometimes as provider and commissioner. New arrangements are now being implemented to put in place an explicit lead commissioning arrangement instead;
- **Progress despite central Government**: in common with the Audit Commission’s findings, our discussions with Torbay managers suggested that integration has been achieved despite lack of central Government commitment to consistent, sustained direction and guidance.

13. Improved performance was reported within two years of the Care Trust being established. Achievements reported so far are:

- Introduction of a single point of access to community care, with significant improvement in waiting times for assessment;
- Reduction in waiting times for packages of care;
- Named social workers for each GP practice, with social workers inputting to GP systems;
- Integrated occupational therapy service;
- District nurses commissioning packages of care;
- A long overdue review of in-house services;
- A review and closure plan for care homes;
- A review of home care including re-shaping of in-house home care provision and tender for external home care services;
- Development of specialist intermediate care support workers;
- Reduced unplanned emergency admissions and acute length of stay among the older population;
- No delayed discharges.
14. In North East Lincolnshire, the partnership between the co-terminous Local Authority and PCT created a Care Trust in September 2007. The integration model in North East Lincolnshire has three components:

- The establishment of a Care Trust to commission and provide adult health and social care services from a pooled budget.
- An integrated Public Health and Wellbeing function managed by the LA.
- A Children’s Trust hosted by the Council.

15. This diagram illustrates the integrated arrangements in North East Lincolnshire; again, the red dotted line represents the flow of resources and the blue solid line represents accountability:

16. Senior managers in NE Lincolnshire report that integrated working across teams has taken root at strategic, tactical and individual levels, which, combined with very strong community engagement, is yielding a range of benefits:

- Use of co-production models for health and personal care, with stronger ownership by patients and service users;
- Broader set of standards in contracts in place reflecting total care issues;
- No cost shunting between the NHS and social care;
- Single point of access to integrated community health and social teams;
- NHS funding of some care substitution services – helping to “turn off the tap” before an admission to hospital becomes inevitable;
- Better – more effective, innovative and less expensive – management of winter pressures.

17. Lead commissioning models do not fit neatly into the organisational relationships described in recently published Department of Health plans to integrate General Practice within the NHS and put in place GP commissioning. We understand
from contacts in the Care Trusts in England that this is a cause for concern there, and that they are in discussion with DH to look for ways of retaining the flexibilities and improvements achieved to date, whilst at the same time accommodating greater involvement of General Practice.

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