

## **Faulty by design.**

The state of public-service  
commissioning.

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# Foreword

## Meg Hillier MP

As the Chair of the Public Accounts Committee, my role is to make sure the Committee is effective at challenging departments on whether they are getting value for money for the taxpayer.

I am delighted *Reform* has researched and analysed the changing and varied ways government is choosing to deliver public services. In a time of restricted resources in the public sector, innovation and transformation can be welcome approaches to address the problems of doing more with less. But it is vital that service users remain at the centre of public services, and new solutions require additional scrutiny to safeguard value for money.

The Government creates huge challenges for itself by transforming so many services at once. The Ministry of Justice is changing the ways it delivers rehabilitation, probation, court interpreters and legal aid as well as reforming the prison estate and court buildings.

The NHS has been restructured and reformed, and has now hit a financial crisis point. Local health economies are encouraged to find innovative ways to deliver services, such as commissioning in ever complex arrangements. But public servants can lack the commercial skills needed to make sound contractual deals that are cost-effective and deliver high-quality services, as we saw recently with the short-lived disastrous UnitingCare Partnership in Cambridgeshire and Peterborough.

Devolution creates all manner of opportunities for local communities to enable those with the best local knowledge to create more responsive, efficient local services. But the Government is negotiating each deal individually and those at the centre of government have too often appeared before the Committee unsure and unclear about who is responsible for what expenditure within new structures such as City Deals. It is crucial that accountability and transparency are not lost with devolved powers.

Our work in the Public Accounts Committee remains one of the most important platforms for Parliament's role in holding the executive to account. We also need the work of think tanks and academics to provide robust analysis and offer external challenge to government.

I am sure you will find this paper as insightful and interesting as I have, and I hope the Government takes note.

**Meg Hillier MP, Chair, Public Accounts Committee**

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# 1 Introduction

How public services are commissioned underpins their success across the public sector: in healthcare, criminal justice, employment services and beyond. If government does not get the commissioning process right, it will not deliver value for money. Specifically, these services will not meet the increasingly complex needs of users across the country, with consequent financial costs to taxpayers.

The act of commissioning these services includes their design, purchase and evaluation, which, by its very nature, should improve service delivery through each iteration (see Figure 1).

**Figure 1: The commissioning cycle**



Contracting third parties to deliver public services is a relatively new approach. Before the 1980s, commissioners rarely procured services from outside the public sector – with the notable exception of general practitioners (GPs). In the last three decades, the split between the purchaser (government) and the provider (private companies, charities or other public-sector bodies) of services has accelerated. Today, virtually every part of the public sector benefits from market mechanisms. Competition drives down prices, increases innovation and allows expert providers to deliver services to meet users' needs.<sup>1</sup>

In recent decades, governments have tried to improve the commissioning process. Reforms have aimed to deliver integrated services that address the complex needs of service users in the most effective way – in many instances through devolving power to local commissioners to design services to meet the different needs of different areas. Major recent reforms include the creation of Clinical Commissioning Groups (CCGs) in 2012 to commission secondary healthcare. The same year, Police and Crime Commissioners (PCCs) were introduced to be held accountable to local areas for tackling crime. More recently, government has devolved the health, social-care, welfare, skills and elements of criminal-justice budgets to Greater Manchester.

<sup>1</sup> National Audit Office, *Delivering Public Services through Markets: Principles for Achieving Value for Money*, 2012; Alexander Hitchcock, Charlotte Pickles, and Alasdair Riggs, *The Work and Health Programme: Levelling the Playing Field* (Reform, 2016).

The purpose of this paper is to evaluate the success of current approaches to commissioning by central government, local authorities and commissioning bodies. To do so, interviews with 29 experts from government, providers and third-parties, were conducted, alongside a literature review and evaluation of the publicly available data. Attention is paid to complex human services, in which there is a purchaser-provider split – in health and social care, criminal justice, housing and homelessness, and employment services. Where these services affect other areas of policy, the paper widens its focus. The aim is to outline a case for change, for commissioners to learn from past actions when approaching commissioning in the future. This is a critical step for future success,<sup>2</sup> and will pave the way for *Reform* to set out a vision for a new commissioning framework in subsequent analysis.

This report reveals that the public sector's approach is imperfect. Recent reforms have acted as sticking plasters, reacting to individual problems independent of one another, rather than addressing the wide variety of (often related) problems service users face – such as health and social-care needs, homelessness, drug and alcohol addiction, unemployment, and crime. These reforms have created a complex and often overlapping commissioning framework, which fails to most effectively address citizens' needs.

This paper looks at three critical and interdependent areas of commissioning. Chapter 2 argues that by focusing on the inputs and outputs of services, rather than outcomes, commissioners are failing to incentivise providers to tackle what matters most to service users. Chapter 3 points to the fragmented commissioning framework and its consequent inability to design services that meet the multiple needs of many people. This results in failure to prevent issues arising, gaps in some services and duplication of others – all causing inconvenience for service users and increased cost for the Exchequer. Chapter 4 shows that, despite recent government policies to create commissioning bodies to meet the variable needs of people in different areas across the country, the localism agenda has not materialised in practice. Despite the creation of new local commissioning bodies, a high degree of central control of the design and aims of services undermines the ability of commissioners to design services to meet the needs of local populations.

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2 Matthew Syed, *Black Box Thinking*, (UK: John Murray 2015).

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# 2

## The illusion of outcomes-based commissioning

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Outcomes-based commissioning is an approach to the planning and contracting of public services which aims to shift the emphasis from what services a provider will offer, to the outcomes they seek for a given population. In practice, there is a distinction between what citizens may want and what commissioners plan to buy.

In recent years, there has been growing consensus that for public services to truly deliver value for money, commissioning needs to be outcomes based.<sup>3</sup> It has been described as the most cost-effective way to deliver more personalised care, tailored to citizens' needs.<sup>4</sup> Whilst the rhetoric for an outcomes-based commissioning model is strong, on the ground, there has been limited progress.<sup>5</sup>

## 2.1 Focusing on the wrong things

The poor on-the-ground expansion of outcomes-based commissioning can be partly attributed to a narrow focus on what can be easily measured. Processes and activities are easier to quantify than outcomes. In addition, shifting current practices to induce a greater use of outcomes-based commissioning requires a radical cultural change. This explains why many commissioners still focus on achievement of output-based targets. One of the characteristics of outcomes-based commissioning is the design of services around the outcomes that matter most to people at the local level. In practice, however, commissioning is more of a one-size-fits-all model.

### 2.1.1 Diktat of what can be easily measured

Current commissioning processes and strategies have failed to have a clear focus on outcomes – instead focusing on inputs (paying for services) and outputs (activities) (see Figure 2).<sup>6</sup> When these become contractual targets, they have the potential to distort priorities.

**Figure 2: Definition of inputs, outputs and outcomes**

<b>Inputs</b>	The resources, such as labour and capital, used to produce activities, outputs and outcomes.
<b>Outputs</b>	The goods or services produced by the inputs. In the public sector, services are the main output.
<b>Outcomes</b>	The ultimate goals or objectives sought by government on behalf of citizens.

The focus on inputs and outputs is in part because these are easiest to measure.<sup>7</sup> In health, for example, delivering a given number of knee operations a year is a more concrete target to achieve than increasing a person's mobility or sense of independence.<sup>8</sup> In social care, it is much easier to count the number of hours of care provided than the impact those hours have on a person's quality of life. These numbers are, of course, useful to collect as they provide an indicator of efficiency, but they fail to consider what really matters (that is, the outcomes delivered).<sup>9</sup>

Not only are outcomes more conceptually difficult to define than inputs and outputs, it is also difficult to decide the appropriate time to measure them. Measuring reoffending is a prime example of this. Currently, the Ministry of Justice simply measures whether people

3 Social Finance, *Commissioning for Outcomes across Children's Services and Health and Social Care*, 2015; Caroline Glendinning et al., 'Progress and Problems in Developing Outcomes-Focused Social Care Services for Older People in England', *Health & Social Care in the Community* 16, no. 1 (January 2008): 54–63; Lauren Lucas and Jonathan Carr-West, *Outcomes Matter: Effective Commissioning in Domiciliary Care* (Local Government Information Unit, 2012); National Audit Office, *Personalised Commissioning in Adult Social Care*, 2016.

4 Dan Crowe, Tom Gash, and Henry Kippin, *Beyond Big Contracts* (Institute for Government, 2014).

5 *Ibid.*, 26.

6 Social Finance, *Commissioning for Outcomes across Children's Services and Health and Social Care*; Crowe, Gash, and Kippin, *Beyond Big Contracts*.

7 Elizabeth Crowhurst, Amy Finch, and Eleonora Harwich, *Towards a More Productive State* (Reform, 2015).

8 Outcomes Based Healthcare, "Myth 1: Outcomes Are Just Too Difficult to Define...", Press Release (n.d., accessed 22 July 2016).

9 Laura White, *Commission Impossible? Shaping Places through Strategic Commissioning* (Localis and Mears, 2011).

reoffend within 12 months of their release from prison. However, some studies have argued that this only creates a partial picture.<sup>10</sup> This type of time-limited binary measure fails to consider other important factors like severity of offence and the time elapsed between the release from prison and the reoffence. International follow-up periods vary between six months and five years, illustrating the diversity of ways in which this outcome can be measured.<sup>11</sup>

The Transforming Rehabilitation strategy, introduced in 2014, is an example of the failure to adequately commission for outcomes and an over focus on ‘process’ targets. The programme is designed to provide through-the-gate services to reduce reoffending. However, there is a clear discrepancy between the general outcome the programme was designed to achieve (reduce reoffending) and the targets set by the National Offender Management Service (NOMS). Community Rehabilitation Companies (CRCs), which deliver probation services, “are paid primarily for specified activities with offenders” rather than for the outcomes they deliver.<sup>12</sup> These activities vary between CRCs and might include signposting offenders to accredited programmes, accommodation or health services or offering a mentor. Transforming Rehabilitation’s 10-per-cent outcomes-payment weighting has not, according to HM Inspectorate of Probation (HMIP), incentivised providers to deliver interventions outside of those mandated by the contract.<sup>13</sup> Though too early to determine the effect on outcomes, the review “found little evidence of the anticipated creativity or innovation in the new services being delivered by the CRCs.”<sup>14</sup>

### 2.1.2 False outcomes

In other instances, providers are paid to deliver outcomes that in practice do not contribute to improved behaviour or results because they are ill defined.

The Troubled Families programme is a clear example. The programme was designed to “turn around the lives” of half a million families (across two iterations) who met defined criteria (see Figure 3).

**Figure 3: Troubled Families definitions**

Wave one (2012)	Wave two (2014)
<p>‘Troubled families’ meet three of the following four criteria:</p> <ul style="list-style-type: none"> <li>&gt; Involved in youth crime or anti-social behaviour</li> <li>&gt; Have children who are regularly truanting or not in school</li> <li>&gt; Have an adult on out-of-work benefits</li> <li>&gt; Cause high costs to the taxpayer</li> </ul>	<p>‘Troubled families’ meet two of the following six criteria:</p> <ul style="list-style-type: none"> <li>&gt; Parents and children involved in crime or anti-social behaviour</li> <li>&gt; Children have not been attending school regularly</li> <li>&gt; Children need help</li> <li>&gt; Adults out of work or at risk of financial exclusion and young people at risk of worklessness</li> <li>&gt; Families affected by domestic violence and abuse</li> <li>&gt; Parents and children have a range of health problems</li> </ul>

Sources: Department for Communities and Local Government, *The Troubled Families Programme: Financial Framework for the Troubled Families Programme’s Payment-by-Results Scheme for Local Authorities, 2012*; Department for Communities and Local Government, *National Evaluation of the Troubled Families Programme: Interim Report Family Monitoring Data, 2014*.

Overseen by the Department for Communities and Local Government, the Troubled

<sup>10</sup> Kevin Marsh and Chris Fox, ‘The Benefit and Cost of Prison in the UK. The Results of a Model of Lifetime Re-Offending’, *Journal of Experimental Criminology* 4, no. 4 (December 2008); Elizabeth Crowhurst and Eleonora Harwich, *Unlocking Prison Performance* (Reform, 2016).

<sup>11</sup> Seena Fazel and Achim Wolf, ‘A Systematic Review of Criminal Recidivism Rates Worldwide: Current Difficulties and Recommendations for Best Practice’, *PLoS ONE* 10, no. 6 (June 2015).

<sup>12</sup> National Audit Office, *Transforming Rehabilitation*, 2016, 9.

<sup>13</sup> HM Inspectorate of Probation, *An Inspection of Through the Gate Resettlement Services for Short-Term Prisoners*, 2016.

<sup>14</sup> *Ibid.*, 7.

Families programme gave local authorities direct control over several streams of central-government funding and freed them from the conditionality generally attached to these funds. Working across policy silos to meet the wider needs of people is a positive approach as it enables a better sequencing of interventions, avoids duplication and prevents gaps in service provision. The Coalition Government claimed that 99 per cent of those on the programme met the criteria of being ‘turned around’.<sup>15</sup>

There are two problems with this claim. The first is what constitutes being ‘turned around’. Individuals can still commit crime, truant or remain unemployed and be considered ‘turned around’. The education ‘outcome’, for example, requires children to have fewer than three fixed-term exclusions and less than 15 per cent unauthorised absence from school in the last three terms.<sup>16</sup> Only 10 per cent of families deemed ‘turned around’ have gained work (volunteering for the Work Programme is considered an outcome).<sup>17</sup> As one interviewee for this paper explained, these measures are “not related to success.”

The second relates to what would have happened to these families without the programme intervention (that is, the counterfactual). As the national evaluation of the programme explained, outcomes payments reflected the gross positive outcomes of the programme, not considering positive outcomes that might have occurred without programme intervention.<sup>18</sup> So while the national evaluation concludes that there was no benefit of the programme, this does not in itself contradict the payments made for turning lives around; they measure different things.<sup>19</sup> The evaluation concluded that £1.3 billion had been wasted on the programme.<sup>20</sup>

Other commissioners have fallen into similar traps. In healthcare, the Quality and Outcomes Framework (QOF) was introduced in 2004 to provide additional funding to GP practices, ostensibly for delivering improved outcomes. QOF is praised for improving services as it rewards GPs for delivering care to those who present at practices.<sup>21</sup> However, it does not provide a broad enough view of outcomes as it fails to consider GPs’ responsibilities to look after the care needs of all registered patients, not only those who present.<sup>22</sup>

In addition, QOF can lead to a skewed portrayal of population outcomes. *Reform* research recently highlighted, for example, that the average QOF cancer score has been 96.5 per cent since 2006, despite late diagnoses contributing to England lagging behind comparable European countries for cancer survival rates.<sup>23</sup>

### 2.1.3 Culture and skills

A further barrier to outcomes-based commissioning is organisational culture and skills.<sup>24</sup> Commissioning for outcomes is a new approach, codified by the 2011 *Open Public Services* white paper.<sup>25</sup> Implementing it therefore requires new approaches. While there are examples of cultural changes in commissioning bodies at all levels of government, including payment-by-results (PbR) healthcare contracts,<sup>26</sup> commissioners remain risk-averse, fail to learn from previous approaches and do not possess the necessary skills to design outcomes-based contracts.

15 Department for Communities and Local Government and Eric Pickles, “Troubled Families Programme Turning 117,000 Lives around”, Webpage, (29 October 2014).

16 Adfam and DrugScope, *The Troubled Families Agenda - What Does It All Mean?*, 2012, 5.

17 Stephen Crossley, *The Troubled Families Programme: The Perfect Social Policy?*, 2015, 6.

18 Laurie Day et al., *National Evaluation of the Troubled Families Programme. Final Synthesis Report*, 2016, 73.

19 Ibid.

20 Day et al., *National Evaluation of the Troubled Families Programme. Final Synthesis Report*.

21 Deloitte, *Primary Care: Today and Tomorrow Improving General Practice by Working Differently*, 2012, 23.

22 Leo Ewbank, Alexander Hitchcock, and Thomas Sasse, *Who Cares? The Future of General Practice* (Reform, 2016), 23–24.

23 Ibid.

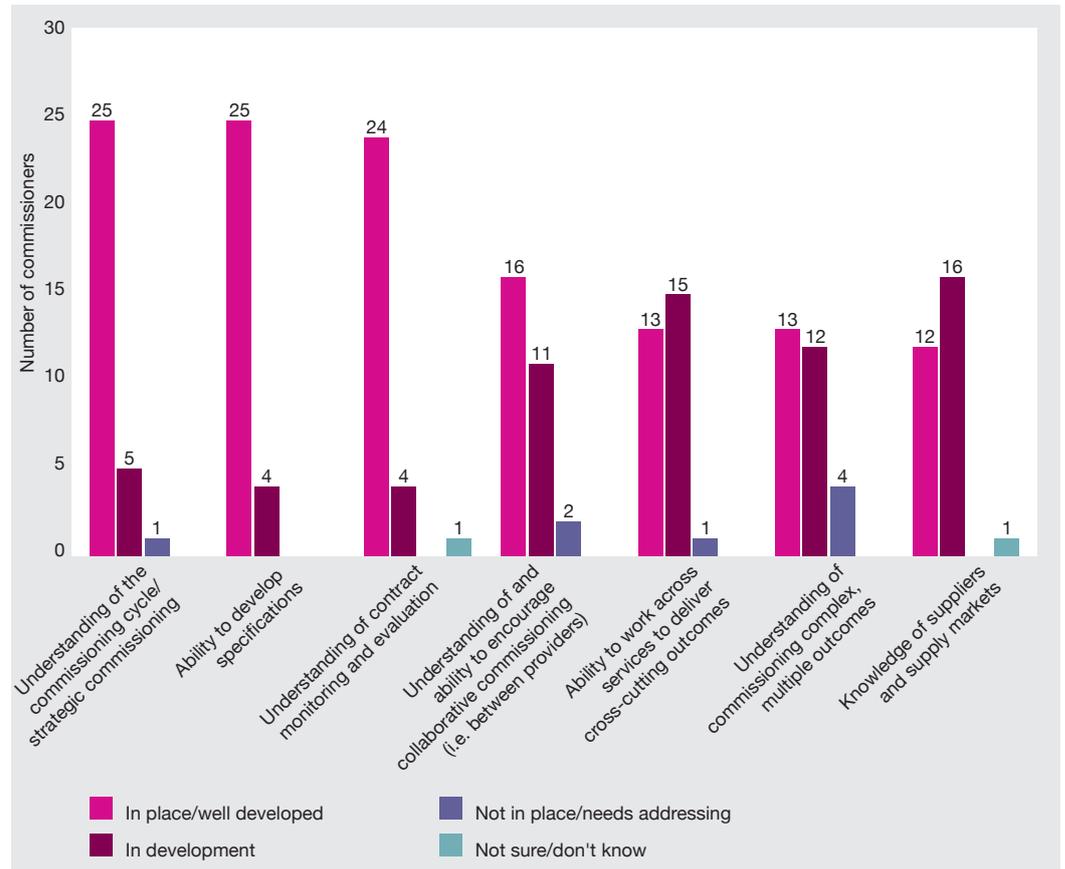
24 C. Glendinning et al., *Outcomes-Focused Services for Older People* (Social Care Institute for Excellence, 2006); Lauren Lucas and Josephine Suherman, *Commissioning in Adult Social Care* (Local Government Information Unit and Mears, 2014).

25 HM Government, *Open Public Services*, 2011.

26 The Health Foundation, *Need to Nurture: Outcomes-Based Commissioning in the NHS*, 2015.

The first area of concern is the variable skillsets of commissioners. Commissioners across policy areas are relatively pessimistic about their ability to contract for cross-cutting outcomes (see Figure 4).

**Figure 4: Commissioners' confidence in skills**



Source: Dan Crowe, Tom Gash, and Henry Kippin, *Beyond Big Contracts* (Institute for Government, 2014).

The National Audit Office (NAO) has found that the capacity of local authorities to deliver personal health budgets – which allow patients to purchase care they believe will best meet their needs – in adult social care varies significantly.<sup>27</sup> Barriers include commissioners failing to see personalised budgets as a means to improved care, and poor forecasts of indicative budgets for users to spend on their needs.<sup>28</sup> This has hampered the effectiveness of some personal health budgets.<sup>29</sup>

Another barrier is a risk-averse attitude to commissioning. Commissioners recognise that contracting for outcomes cedes control of services – a particularly difficult approach in a financially tight environment.<sup>30</sup> Accordingly, commissioners point to a positive relationship between the cost of the contract and its prescriptiveness as managers are particularly keen to ensure these contracts do not fail.<sup>31</sup> Interviewees for this paper also identified a blame culture: commissioning bodies were predominantly known for failed contracts, with press stories focusing on things that have gone wrong. Interviewees argued that this leads commissioners to fall back on repeating processes that have not caused problems in the past. As one interviewee put it: “You can’t be sacked for not being inventive enough.” A risk-averse approach therefore represents a misplaced attitude to risk: if

<sup>27</sup> National Audit Office, *Personalised Commissioning in Adult Social Care*, 10.

<sup>28</sup> *Ibid.*

<sup>29</sup> *Ibid.*

<sup>30</sup> Jenny Harlock, *From Outcomes-Based Commissioning to Social Value? Implications for Performance Managing the Third Sector*, 2014, 19.

<sup>31</sup> *Ibid.*

contracts are not delivering the outcomes people need and care about (especially over the long term), services are hardly working for users.

Though commissioners should look to learn from both successful and unsuccessful approaches to contract design, this has not happened. The NAO has previously argued that “commissioners are in danger of ‘reinventing the wheel’” when designing outcomes payments because approaches, and data on their effect, are not shared across central government, let alone between local commissioners.<sup>32</sup> In a report on child-protection services, for example, the NAO underlined that “arrangements for developing, identifying and sharing good practice are piecemeal.”<sup>33</sup> Social workers are often unaware of the actions taken by local authorities that have well-functioning child-protective services. The report highlighted that “spreading good practice is a challenge.”<sup>34</sup>

A further problem of siloed thinking is revealed by the split between ‘commissioners’, who design services, and ‘procurement officials’, who purchase services from providers.<sup>35</sup> Commissioners complain that their high-level objectives are transformed into highly specific output, or even process, measurements.<sup>36</sup> The issue of this siloed culture has been relayed by central-government commissioners in several departments during interviews with *Reform* for previous research.<sup>37</sup> The point can also be extended across government: as Chapter 3 argues, commissioners struggle to work together to design services aimed at delivering similar outcomes for users across different policy areas.

## 2.2 Not knowing what works

A failure to identify and focus on outcomes is compounded by a lack of understanding about ‘what works’ in a range of policy areas. This happens for several reasons. First, because establishing causal links between a policy intervention and a social outcome is extremely complex.<sup>38</sup> This seems to have led to a lack of measurement, or sometimes poor measurement, in certain policy areas. Second, there is a lack of dissemination of best practice. Too often commissioners and providers remain unaware of the evidence.

In health, Nicholas Black has explained that the link between quality of care and outcomes is not straightforward to establish.<sup>39</sup> It necessitates the collection of a large enough sample of data and personal information about the service user to be able to draw robust conclusions. When gathering data on the outcomes delivered by a specific medical intervention (increased mobility due to a hip replacement operation, for example), it is important to collect information on personal characteristics known to affect the outcome, including the number of physiotherapy sessions following the operation and the weight of the patient. In its report on the Troubled Families programme, the NAO noted that the “sample described in the report is not necessarily representative of all the families that the programme helped”,<sup>40</sup> which calls into question the generalisability of the results on the impact of the intervention. In addition, assessing the best time to measure an outcome after an intervention “to be able to attribute it to that intervention is often contentious”.<sup>41</sup>

A related difficulty, evidenced in Troubled Families, is obtaining a reliable counterfactual. Without this, it is impossible to identify whether “improvements are due to the intervention

32 National Audit Office, *Outcome-Based Payment Schemes: Government's Use of Payment by Results*, 2015, 8.

33 National Audit Office, *Children in Need of Help or Protection*, 2016, 8.

34 Ibid.

35 J. Gordon Murray, ‘Towards a Common Understanding of the Differences between Purchasing, Procurement and Commissioning in the UK Public Sector’, *Journal of Purchasing and Supply Management*, Special Topic Forum: EurOMA Conference 2008, 15, no. 3 (September 2009): 198–202.

36 Crowe, Gash, and Kippin, *Beyond Big Contracts*, 43.

37 These interviews took place in 2016 as part of research for Hitchcock, Pickles, and Riggs, *The Work and Health Programme: Levelling the Playing Field*.

38 Tony Bovaird, ‘Attributing Outcomes to Social Policy Interventions – “Gold Standard” or “Fool’s Gold” in Public Policy and Management?’, *Social Policy & Administration* 48, no. 1 (February 2014).

39 Nicholas Black, ‘Patient Reported Outcome Measures Could Help Transform Healthcare’, *British Medical Journal* 346, no. 1 (January 2013).

40 National Audit Office, *The Troubled Families Programme: Update*, 2016, 16.

41 Black, ‘Patient Reported Outcome Measures Could Help Transform Healthcare’, 3.

or would have happened anyway”.<sup>42</sup> A similar issue was underlined by previous *Reform* research, which found a lack of knowledge of ‘what works’ in employment support for people with health conditions.<sup>43</sup> There are sophisticated statistical techniques to identify counterfactuals,<sup>44</sup> but these are based on assumptions that do not always hold. Experimental policy set ups, such as randomised control trials, are also a way to obtain a counterfactual. However, they are costly to run and can sometimes pose ethical challenges, such as denying a potentially beneficial policy intervention to the control group (which does not receive interventions).

Likewise, understanding what works to prevent reoffending can be complicated due to issues of attribution. The risk factors (drug usage, accommodation and employment upon release into the community, in-prison attitudes, and behaviour and truancy in childhood) are well-evidenced.<sup>45</sup> Yet, evidence on the interventions that reduce reoffending is much patchier.<sup>46</sup> It is not clear which programmes carried out in prison or in CRCs effectively reduce levels of reoffending. This is because it is difficult to isolate the impact of a specific intervention whilst controlling for all environmental factors that might have an impact on reoffending. Gaining an understanding of ‘what works’ to tackle a given problem is sometimes undermined by the sheer complexity of the issue at hand.

In education, a recent Ofsted report on children from disadvantaged backgrounds underlined that service providers had a lack of understanding of “what success looks like in tackling disadvantage.”<sup>47</sup> To improve outcomes for service users, commissioners should disseminate best practice.<sup>48</sup>

The lack of understanding about the effectiveness of certain policy interventions and what constitutes best practice prevent the expansion of outcomes-based commissioning. Without a greater development of the knowledge base and better dissemination of the existing expertise, commissioners will not be able to deliver value for money. The Coalition Government’s creation of ‘what works centres’ is a positive step. The initiative was launched in March 2014 and covers seven different areas ranging from educational achievement to health and social care.<sup>49</sup>

## 2.3 Failing to harness the power of data

It will, however, take time before commissioners and providers will be able to reap the full benefits of the research produced by ‘what-works centres’. In the meantime, government departments and commissioners must harness the full potential offered by current data and analytics. Increasing the quality of data and making better use of what is already available could lead to more-effective public services at a lower cost to taxpayers.<sup>50</sup>

### 2.3.1 Data quality

As it stands, commissioners have failed to use data to improve service design. In a range of areas, the poor quality of data collected has been a barrier to delivering value for money.

Poor-quality data can have several impacts on the commissioning process. They contribute to the problem of understanding what constitutes an effective intervention. DCLG has very little data on outcomes for children in need of child protective services, for

42 National Audit Office, *The Troubled Families Programme*, 8.

43 Ben Dobson, Charlotte Pickles, and Hannah Titley, *Stepping Up, Breaking Barriers. Transforming Employment Outcomes for Disabled People*. (Reform, 2016).

44 For example: Propensity Score Matching and Regression Discontinuity Design.

45 Ian Brunton-Smith and Kathryn Hopkins, *The Factors Associated with Proven Re-Offending Following Release from Prison: Findings from Waves 1 to 3 of Surveying Prisoner Crime Reduction* (Ministry of Justice, 2013).

46 Elizabeth Crowhurst and Eleonora Harwich, *Unlocking Prison Performance*.

47 Ofsted, *Unknown Children – Destined for Disadvantage?*, 2016.

48 New Economics Foundation, *Commissioning for Outcomes and Co-Production: A Practical Guide for Local Authorities*, 2014.

49 Cabinet Office, “What Works Network”, Webpage, 6 August 2015.

50 House of Commons Science and Technology, *The Big Data Dilemma Fourth Report of Session 2015–16*, HC 468 (The Stationery Office, 2016), 11.

example, which means that it has not been able to adequately understand “which approaches provide the most effective help and protection.”<sup>51</sup>

Issues with data quality can also “hinder financial planning”,<sup>52</sup> and prevent an understanding of “future budget demand”.<sup>53</sup> The NAO has pointed out that NHS England had failed to stick to its 2013-14 budget because it was based on “poor-quality data.”<sup>54</sup> The NAO has also found that failure by the Ministry of Justice to provide suppliers with accurate information led to forecasts of demand for rehabilitation programmes that were between 6 and 36 per cent above actual case volumes.<sup>55</sup> These examples show the existence of clear inefficiencies caused by data quality, which affect value for money.

Some public services suffer more than others from data-quality issues. This is particularly true of the prison and probation services.<sup>56</sup> As of December 2015 – almost a year after Transforming Rehabilitation’s introduction – the NAO reported that NOMS had no data on three CRCs and five National Probations Service (NPS) providers.<sup>57</sup> In addition, a further two CRCs and two NPS providers reportedly had insufficiently robust data.<sup>58</sup> The NAO concluded that the performance of CRCs and the NPS “remains unclear given limitations around data quality and availability”.<sup>59</sup> These issues are so profound that NOMS has only been able to apply service credits against one of the Key Performance Indicators used to performance manage CRCs and NPS.<sup>60</sup>

One of the contractual targets for CRCs is to complete screenings of offenders within 72 hours.<sup>61</sup> This screening provides the basis of a prisoner’s needs assessment and is crucial for the provision of resettlement services. It is meant to identify if prisoners have difficulties in terms of accommodation, education, training and employment, substance misuse, debt and several other areas. It is a crucial step in the delivery of better outcomes. Nevertheless, there is no ‘quality control’ attached to the achievement of this target.<sup>62</sup> A joint inspection report recently found that 40 per cent of these screenings were not “adequately described” and the overall quality of them was poor.<sup>63</sup>

### 2.3.2 Data use

In other instances, data are collected on outcomes. The benefits of this information are not realised by commissioners, however, when it is not used to design services.

Information on clinical and social outcomes is often already collected in databases such as QOF or the NHS Safety Thermometer.<sup>64</sup> Used in conjunction these data sources could allow for a better understanding of outcomes. In fact, for a “typical patient segment, data exists which allows 50% to 60% of outcomes to be measured”.<sup>65</sup> These data are underused, which the literature attributes to a lack of data integration between NHS services.<sup>66</sup> Data are currently fragmented in silos.<sup>67</sup> Typically, health and social-care data are held separately, hampering any possibility of understanding complex needs or measuring complex outcomes. In addition, social-care data are not always coded with an NHS identifier which makes the data-matching process across health and social care difficult.<sup>68</sup>

51 National Audit Office, *Children in Need of Help or Protection*, 8.

52 Social Finance, *Commissioning for Outcomes across Children’s Services and Health and Social Care*.

53 *Ibid.*

54 National Audit Office, *The Commissioning of Specialised Services in the NHS*, 2016.

55 National Audit Office, *Transforming Rehabilitation*, 43.

56 Elizabeth Crowhurst and Eleonora Harwich, *Unlocking Prison Performance*.

57 National Audit Office, *Transforming Rehabilitation*, 7.

58 *Ibid.*

59 *Ibid.*, 6.

60 National Audit Office, *Transforming Rehabilitation*.

61 HM Inspectorate of Probation, *An Inspection of Through the Gate Resettlement Services for Short-Term Prisoners*.

62 National Audit Office, *Transforming Rehabilitation*.

63 HM Inspectorate of Probation, *An Inspection of Through the Gate Resettlement Services for Short-Term Prisoners*, 17.

64 Outcomes Based Healthcare, “Myth 2: Outcomes Are Just Too Difficult to Measure...”, (n.d., accessed 22 July 2016).

65 *Ibid.*

66 *Ibid.*

67 Oleg Bestsenyy, Tom Kibasi, and Ben Richardson, *Understanding Patients’ Needs and Risk: A Key to a Better NHS*, 2013.

68 *Ibid.*

Yet some NHS commissioning bodies have managed to use data to segment population need and reveal insights into future demand.<sup>69</sup> A pilot in north west London used data on hospital activity, length of stay, and costs for acute care and social care. The exercise, however, required expertise from external consultants, who noted that commissioners required sophisticated data extraction and analysis skills to exploit the approach.<sup>70</sup> This renders it unlikely that commissioners across the country can replicate the work.

Elsewhere, government is making headway. In Manchester, the New Economy in co-operation with the Government built the 'Unit Cost Database', which provides a rich, yet underused, source of information on the costing of outcomes. It covers areas such as crime, education and skills, employment and the economy, fire, health, housing and social services.<sup>71</sup> The database centralises the results derived from government reports and academic studies and provides more than 600 cost estimates.<sup>72</sup> In addition, it also includes information on the agencies bearing the cost and/or making the fiscal saving. There is a long way to go, however, before all public services collect and use the appropriate data to design services that meet user needs.

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69 Ibid.

70 Ibid.

71 New Economy, *Unit Cost Database*, 2015.

72 Ibid.

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# 3

## Fragmented commissioning

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Government has long aimed to better ‘integrate’ public services – that is, deliver multiple, similar services either through close location or co-location, reducing the number of interventions people receive. Since it is not uncommon for people to receive help from a dozen services, this is better for users, who can receive assistance in the most effective place, and for taxpayers, who do not have to pay for repeated or avoidable interventions.<sup>73</sup>

To achieve this, recent governments (at both national and local levels) have aimed to build services around users. This means designing services that meet individuals’ needs, not follow siloed processes set by service boundaries and traditional ways of working. As the Coalition Government recognised: “Individuals, families and communities have complex needs, which don’t neatly align with the traditional boundaries of public services.”<sup>74</sup> Despite recent governments’ stated aims, commissioning remains highly fragmented. Governments have amended the commissioning framework in a piecemeal fashion – rather than taking a system-wide view of commissioning. This chapter focuses on the fragmentation of commissioning within and across policy areas. The next focuses on poor working between central and local government.

### 3.1 The integration agenda

#### 3.1.1 Government approaches

Recent Governments have held four key motives for integrating services:

- > **improved outcomes for service users:** focusing on outcomes important to citizens, instead of meeting the needs of the system;
- > **cost-effective services:** removing unnecessary duplication, such as different bodies commissioning similar services for users;
- > **improved access to resources:** combining budgets, skills and expertise and thereby overcoming barriers to joint investment, such as where one commissioner spends, but others benefit; and
- > **incentives to improve value for money:** responsibility for services to motivate commissioners to spend wisely.<sup>75</sup>

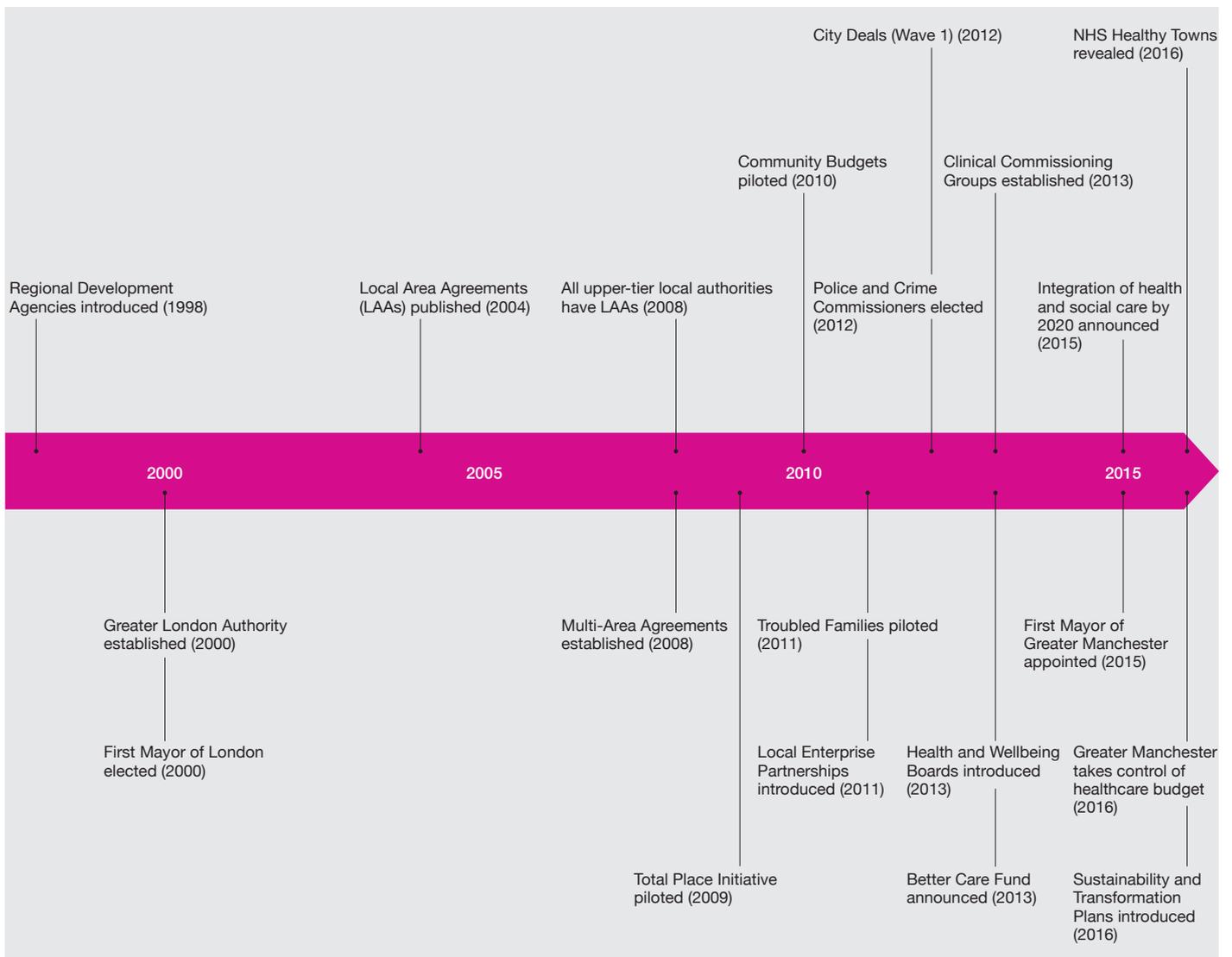
In 2014, the Coalition Government argued it was “encouraging and even mandating more integrated working and more collaboration between services.”<sup>76</sup> This announcement has been flanked by a raft of changes to commissioning bodies (see Figure 5). Pooled budgets between commissioners, as in the case of the devolution deal with Greater Manchester, and bodies designed to bring together disconnected parts of the healthcare system, such as Health and Wellbeing Boards, are clear attempts to create the incentives for officials to commission integrated services. Other headline programmes, such as Troubled Families, look to cut across Whitehall silos, with departments combining budgets to deliver a range of services – including employment, mental health and housing – to meet the complex needs of those with multiple challenges. Although a small proportion of the population, people with multiple challenges are the most expensive group per head.

<sup>73</sup> Sarah Anderson, *Summing up: Revolving Doors Agency’s Key Learning 2000-2009* (Revolving Doors Agency, 2010).

<sup>74</sup> Cabinet Office, *Open Public Services 2014*, 2014.

<sup>75</sup> National Audit Office, *Measuring the Costs and Benefits of Whole-Place Community Budgets*, 2013, 5–6.

<sup>76</sup> Cabinet Office, *Open Public Services 2014*.

**Figure 5: Timeline of selected policies to promote integration**

### 3.1.2 Current framework

Policies to integrate services have, however, resulted in a patchwork of changes – reacting to problems *ad hoc*, rather than building a coherent approach to commissioning. Commenting on recent changes, the House of Commons Library wearily notes:

*Community budgets are the latest incarnation of a policy issue which has been in existence for at least twenty years. This is how to reduce policy spending on government functions ('silo government') in favour of spending on people and areas (policy and spending based on territory).<sup>77</sup>*

One interviewee for this report commented that changes now “feel like Groundhog Day.”

The result is fragmented, overlapping commissioning of services. The NAO argued in 2013 that, though government has taken “tentative steps” to integrate services:

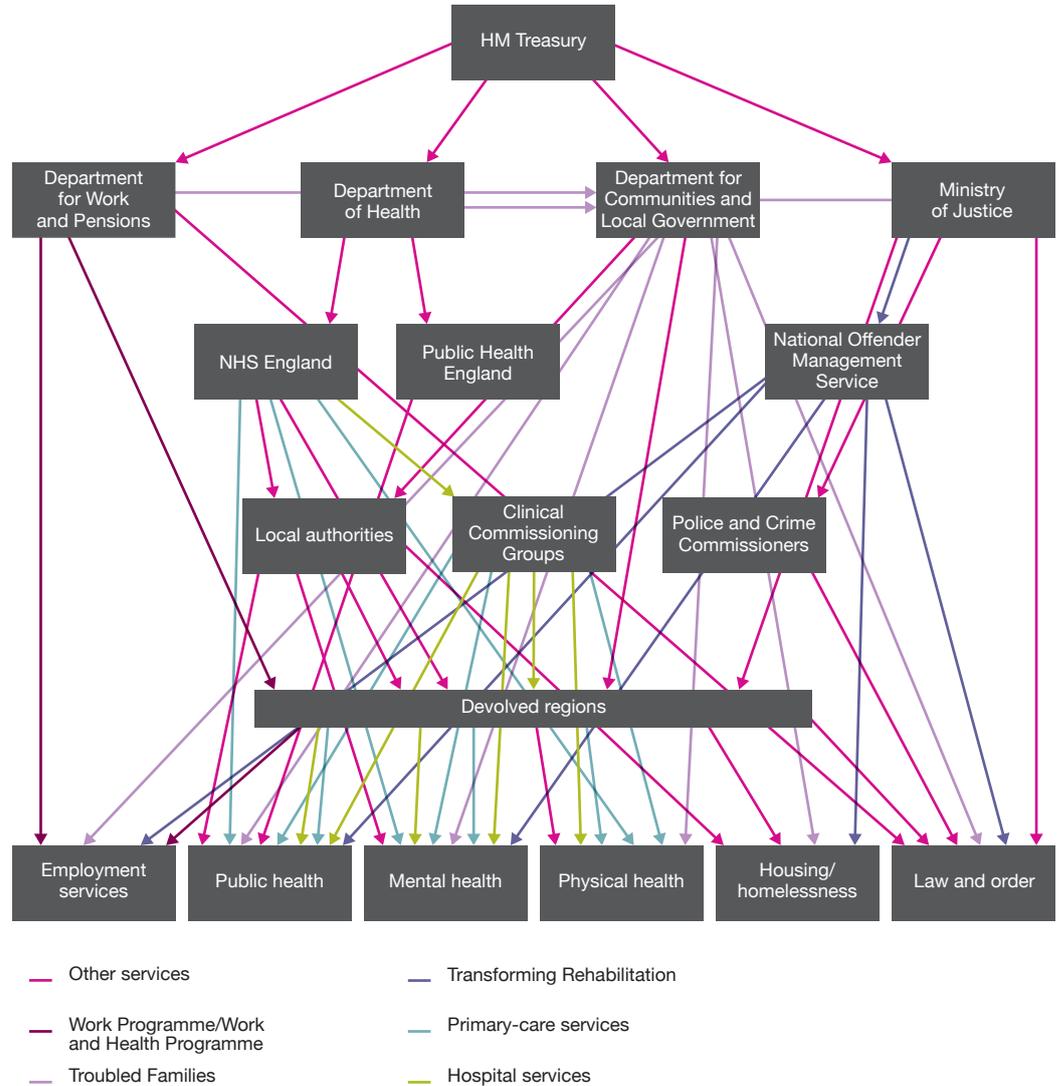
*There remains much room for improvement. Short-term thinking, a lack of integration in many areas and poor evidence gathering are impairing effective adoption and implementation of early action across government.<sup>78</sup>*

<sup>77</sup> Mark Sandford, *Community Budgets and City Deals* (House of Commons Library, 2015), 4.

<sup>78</sup> National Audit Office, *Early Action: Landscape Review*, 2013.

The funding structure of key Whitehall departments, local commissioning bodies and services fails to incentivise the commissioning of joined-up provision (see Figure 6). For this reason, numerous interviewees explained that, given a blank sheet of paper, they would not have designed such a complex commissioning framework.

**Figure 6: Money flow from selected commissioning bodies**



### 3.2 The cost of fragmentation

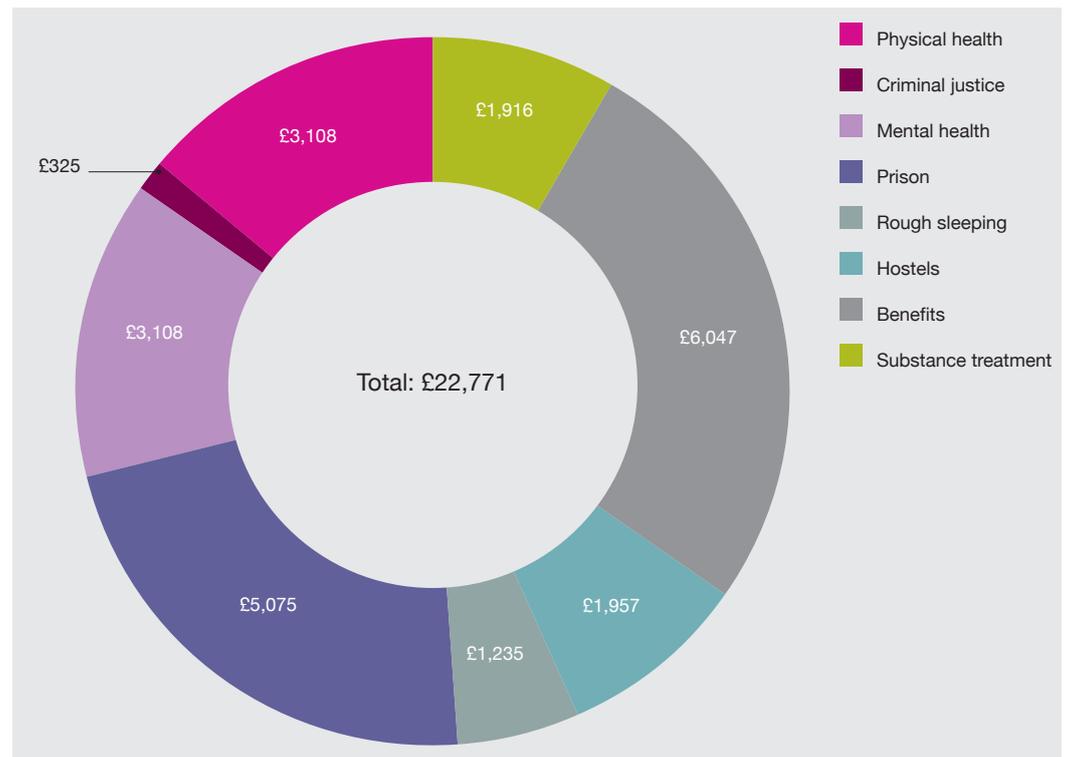
#### 3.2.1 Those with multiple and complex needs

Integrated programmes aim to help cohorts which interact with multiple services. According to Glen Bramley and Suzanne Fitzpatrick, 586,000 people in England fall into the “severe and multiple disadvantage” (SMD) group – meaning they face problems caused by at least one of the three issues of homelessness, substance misuse and crime – with poverty and mental-health problems being nearly universally present.<sup>79</sup> These are people who interact with the related services to differing extents, partly dependent on the number of these problems they face, with almost 60,000 facing all three.

<sup>79</sup> Glen Bramley and Suzanne Fitzpatrick, *Hard Edges: Mapping Severe and Multiple Disadvantage, England* (Lankelly Chase Foundation, 2015), 6.

Providing services to support people with SMD is expensive. In 2015, HM Treasury estimated government spent a total of £10.1 billion on people with one or more SMD (£4.3 billion of which was on people with two or more).<sup>80</sup> Each person facing all three problems will cost taxpayers £23,000 a year (see Figure 7).

**Figure 7: Annual public spending for those with three severe and multiple disadvantage profiles, per person**



Source: Glen Bramley and Suzanne Fitzpatrick, *Hard Edges: Mapping Severe and Multiple Disadvantage, England* (Lankelly Chase Foundation, 2015).

Note: These figures have been updated to reflect 2016-17 prices.<sup>81</sup>

These costs further accumulate the longer people require services. The average person receiving help for three SMDs in Bramley and Fitzpatrick's study had cost the Exchequer close to £250,000 over their lifetime (to the date they were interviewed); the total cumulative cost of SMD groups is estimated to be as high as £58 billion.<sup>82</sup> This creates a clear and compelling case for the integration of services for people who require assistance from numerous different providers.

### 3.2.2 Gaps in services

The design of services by different commissioning bodies can lead to a failure to commission services to act in the most effective manner. Contributing to this is poor information sharing, differing priorities and a lack of clarity as to who is responsible for interventions or outcomes.

#### 3.2.2.1 Failure to share information

With so many bodies funding services for similar needs, responsibility for commissioning services can become unclear. This can result in services not being delivered at all. In the worst cases, these gaps can result in fatalities – such as in instances of child abuse not

<sup>80</sup> HM Treasury, *Budget*, 2015, 30; Bramley and Fitzpatrick, *Hard Edges: Mapping Severe and Multiple Disadvantage, England*, 41.

<sup>81</sup> HM Treasury, *GDP Deflators at Market Prices, and Money GDP: November 2016*, 2016.

<sup>82</sup> Bramley and Fitzpatrick, *Hard Edges: Mapping Severe and Multiple Disadvantage, England*, 43.

being identified. A recent government review of suspected child abuse cases identified insufficient information sharing and silo-working between organisations at local level as common issues – with healthcare professionals, social-service workers and school staff working within their narrow remits and not sharing safety concerns or health issues with one another.<sup>83</sup> Commissioners are best-placed to oversee the sharing of this information, but silos remove responsibility from any one commissioning body.

Similarly, lack of information sharing has been identified as a factor in cases of murder. For example, mental-health sufferers who have committed these crimes have been passed from one treating team to another, from their GP (then commissioned by NHS England) to a specialist mental-health service (commissioned by the CCG), without all the information on their condition being shared between providers.<sup>84</sup> A review into deaths of people with learning disabilities and mental-health problems in contact with Southern Health NHS Foundation Trust, for example, identified a lack of information sharing between health and social-care providers.<sup>85</sup> Both information governance issues and a lack of incentives to address the whole picture (as services are commissioned and funded by different bodies) contributed to poor information sharing.

### 3.2.2.2 Differing priorities

Elsewhere, different outcome and spending priorities inhibit multiple commissioners designing services which best meet the needs of users. An example is provided by probation services. When implementing Transforming Rehabilitation, it was recognised that reoffending had remained consistently high at between 26 and 27 per cent since 2004, at the cost of £9.5 billion to £13 billion a year.<sup>86</sup> To tackle this, policymakers argue there should be greater focus on providing services to address some of the problems that reoffenders disproportionately experience, compared to the general population (see Figure 8).<sup>87</sup>

**Figure 8: Characteristics of reoffenders, 2013**

Characteristic	Percentage of reoffenders (ex-prisoners)	Percentage of general population
Homeless (16+)	19.78%	0.39% (in the past year)
Unemployed (16+)	20.45%	7.6% (June 2013)
Used class-A drugs (16+)	46.54% (since release)	8.20% (in the past year)

Sources: Ministry of Justice, *The Factors Associated with Proven Re-Offending Following Release From Prison: Findings From Waves 1 to 3 of SPCR, 2013*; Home Office, *Drug Misuse: Findings from the 2012 to 2013 Crime Survey for England and Wales, 2013*; Department for Communities and Local Government, *Homelessness Prevention and Relief: England 2012/13 Official Statistics, 2013*; National Archives, *UK Population Estimates 2013, 2014*; BBC News, *Economy Tracker: Unemployment, March 2015*.

Note: these statistics are based on a sample of around 1,330 ex-prisoners.

Receiving timely support to address these needs is therefore crucial to reducing reoffending. Different bodies, with different aims, paying for different interventions reduces the incentives to take the ‘whole-person’ approach to delivering interventions. For example, commissioning drug and alcohol services falls under the remit of public-health commissioners – namely local authorities. With funding pressure being a key priority, and

83 Peter Sidebotham et al., *Pathways to Harm, Pathways to Protection: A Triennial Analysis of Serious Case Reviews 2011 to 2014* (Department for Education, 2016).

84 Androulla Johnstone, *Independent Investigation into the Care and Treatment Provided to Mr X, Ms Y and Mr Z by the Dorset HealthCare University NHS Foundation Trust* (Health and Social Care Advisory Service, n.d.).

85 Bob Green et al., *Independent Review of Deaths of People with a Learning Disability or Mental Health Problem in Contact with Southern Health NHS Foundation Trust April 2011 to March 2015* (Mazars, 2015).

86 Home Office and Ministry of Justice, “2010 to 2015 Government Policy: Reoffending and Rehabilitation”, Webpage, (8 May 2015).

87 Ministry of Justice, *Prison Safety and Reform, 2016*.

local authorities not footing the immediate bill for health complaints or offending costs, 72 per cent are planning to cut these budgets.<sup>88</sup>

When services are integrated, they have delivered positive results. For example, the reoffending rate for female prisoners who received support from women's centres for a range of health, crime and employment problems was 30 per cent, compared to 35 per cent for the control group.<sup>89</sup> Yet, these services are universally available, and are not commissioned coherently across the country – with some centres commissioned by NHS England or CCGs and others by the Ministry of Justice through NOMS – each of which has different priorities for the centres.<sup>90</sup>

### 3.2.2.3 Ambiguity of responsibility

In other instances, commissioner uncertainty as to which body is responsible for providing interventions has undermined delivery. It recently took the Court of Appeal to decide that NHS England (not local authorities, as the NHS argued) should fund the pre-exposure prophylaxis drug (Prep), after a dispute as to whether it fell within the remit of public health.<sup>91</sup> This has delayed the commissioning of a drug capable of limiting the spread of HIV.

This reflects the Health Select Committee's warning that moving public-health commissioning to local authorities in 2013 has created elements of "confusion" between the NHS and local authorities.<sup>92</sup> One witness raised concerns that cervical-screening tests are no longer routinely provided in local-authority-commissioned sexual-health clinics following responsibility being transferred to NHS England.<sup>93</sup> Moving responsibility for these services from a body tasked with preventing illness to one that focuses on reactive care may lead to increased pressure on hospital services, likely at a higher cost and greater harm to patients.

### 3.2.3 Issues not prevented

A key way to improve outcomes and save money is to prevent issues from arising in the first instance. This has been front and centre of the healthcare debate in recent years, with the NHS's *Five Year Forward View* calling for the service to get "serious about prevention".<sup>94</sup> Prevention takes many guises, from avoiding issues arising in the first instance (primary prevention) to ensuring that people's current problems do not deteriorate (secondary prevention).

The benefits of prevention are clear: averting issues before they occur not only increases the wellbeing of citizens but also reduces the demand for services.<sup>95</sup> These benefits can be reaped within one service area – where a GP intervention stops a patient requiring hospital treatment, for example. They can also be received across service areas, such as where services supporting people into sustained employment prevent homelessness.<sup>96</sup>

Preventing issues will reduce costs in the future. Numerous figures have been quoted in the literature, and Figure 9 provides an indicative amount across several policy areas.

88 Association of Directors of Public Health, *Impact of Funding Reductions on Public Health*, 2016, 2.

89 A result that was found to be statistically significant. Ministry of Justice, "Justice Data Lab: Re-offending Analysis: Women's Centres throughout England", Webpage, (2016).

90 National Audit Office, *Funding of Women's Centres in the Community*, 2013; Clinks, *Lancashire Women's Centres. Case Study of Good Partnership Practice between the Health and Care Sector and the Voluntary Sector*, 2014.

91 BBC News, 'NHS England Has Power to Fund Prep HIV Drug, Court Decides', 10 November 2016.

92 House of Commons Health Committee, *Public Health post-2013. Second Report of Session 2016-17*, 2016, 36.

93 Ibid.

94 NHS England, *Five Year Forward View*, 2014, 10.

95 Department for Work and Pensions, *Early Intervention: The next Steps*, 2011.

96 Homeless Link, *The Unhealthy State of Homelessness: Health Audit Results 2014*, 2014, 11.

**Figure 9: Cost of failure to prevent issues**

Issue	Annual direct cost to the Exchequer
Obesity	£6.3 billion
Trips and falls	£2 billion, with 35 per cent increase in acute costs in the year following.
Smoking	£2 billion
Poor diet	£4 billion
Alcohol-related incidents	£3.5 billion (NHS); £11 billion (crime)
Homelessness	£1 billion
Drug abuse	£13.9 billion (crime); £2.4 billion (NHS); £3 billion (welfare)
Troubled families	£9 billion

Sources: Public Health England, *Economic Impact*, n.d.; Public Health England, *Local Action on Health Inequalities*, 2014; Ash, *The Economics of Tobacco*, 2015; Public Health England, *Alcohol Treatment in England 2013-14*, 2014; Alcohol Concern, *Statistics on Alcohol*, n.d.; Department for Communities and Local Government, *Evidence Review of the Costs of Homelessness*, 2012.

### 3.2.3.1 Prevention within current policy areas

A barrier to preventing issues is the current commissioning framework. Fragmented responsibilities and the inability to reap the reward of interventions when they accrue elsewhere has failed to incentivise commissioners to design services which prevent problems within and across service areas.

The clearest example of commissioners failing to incentivise prevention within a policy area is healthcare. Here, different funding streams fail to give responsibility for the whole care needs of patients to any one body. Whereas GPs receive 'capitated' (per person, weighted for basic characteristics) funding for registered patient lists (from NHS England), hospitals are mostly funded per intervention delivered (by CCGs).<sup>97</sup> This incentivises the intervention being delivered in the least effective area: GPs are incentivised to reduce care, while hospitals are incentivised to increase it. NHS Improvement (then Monitor) explained that NHS funding streams "tend to fragment care and are inconsistent with the delivery of integrated care."<sup>98</sup> As one NHS Trust leader interviewed for this paper put it: "There are limited incentives for healthcare providers to deliver [value for money], if the recipient of the 'value' lies elsewhere in the pathway. This is the concept of the 'fruit of the tree falling in your neighbour's garden'." For example, £597 million is wasted each year on A&E appointments that resulted from patients presenting at A&E after failing to get a less-costly GP appointment.<sup>99</sup>

The separation of public-health commissioning (under the remit of local authorities and Public Health England) and healthcare commissioning has stood in the way of integration elsewhere in the NHS. According to Dr Eugene Miller, Director of Public Health at Newcastle County Council, prevention is seen as "no longer the responsibility of people practicing [sic] in the NHS...[who say:] 'Tobacco is no longer our problem, it is in the local authority now and we do not need to do that'."<sup>100</sup> Only 4 per cent of NHS spend is on public health.<sup>101</sup> This creates huge, potentially avoidable, costs for the NHS (see Figure 9).

Recent policies have not delivered integration, however. Health and Wellbeing Boards – designed to act as a link between local authorities and CCGs – have no formal commissioning powers and have not, according to the Health Select Committee and the

<sup>97</sup> Leo Ewbank, Alexander Hitchcock, and Thomas Sasse, *Who Cares? The Future of General Practice*.

<sup>98</sup> Monitor, *Capitation: A Potential New Payment Model to Enable Integrated Care*, 2014.

<sup>99</sup> Reform calculations. Based on an average A&E appointment costing £124, compared to a GP appointment costing £21. National Audit Office, *Stocktake of Access to General Practice in England*, 2015.

<sup>100</sup> House of Commons Health Committee, *Public Health post-2013. Second Report of Session 2016-17*, 62.

<sup>101</sup> *Ibid.*, 9.

King's Fund, provided (in the words of the latter) "genuine system leadership".<sup>102</sup> Policymakers have identified Sustainability and Transformation Plans as levers to deliver better public health,<sup>103</sup> but some draft plans are silent on public health.<sup>104</sup> As a group of academics recently argued, there is little evidence that 'partnerships' such as these – acting as go-betweens for commissioners – have been successful in healthcare.<sup>105</sup>

The Department for Work and Pensions has likewise looked to save money on the benefits bill by helping people into work. As long ago as 2007, David Freud estimated that the annual saving of moving an Incapacity Benefit claimant into work was £9,000.<sup>106</sup> Gainful employment not only saves the DWP money, it can reduce usage of council services, health services and, most importantly, improve people's wellbeing.<sup>107</sup>

### 3.2.3.2 Prevention across current policy areas

Public services should, however, go further and address issues that transcend current service boundaries. Interviewees for this paper characterised this integration of prevention as one of the biggest challenges for commissioning bodies accustomed to designing siloed services.

Health and social care is a clear example of this. Half of adult social care is used by over 65s who suffer from one or more long-term condition.<sup>108</sup> Yet much care that could prevent patients ending up in hospital is not delivered in people's homes. For example, the NHS spends £600 million a year treating preventable injuries sustained at home.<sup>109</sup> The separate funding of social care (by individuals and local authorities) and hospital care (by CCGs) fails to incentivise integrated care being delivered.<sup>110</sup> The King's Fund has warned of the short sightedness of recent cuts – with local authorities spending 9 per cent less in real terms on adult social care between 2010-11 to 2015-16, compared to NHS England spending 9 per cent more across the same period – with costs being pushed on to unpaid carers and the NHS.<sup>111</sup>

Delivering integrated care will not eliminate over-65s' NHS bed use, of course. Yet integrated health and social-care delivery models – delivered by pioneering providers and commissioners who have acted despite the system, according to interviewees – show what can be achieved. In one instance, a housing association partnered with a hospital to provide a flat (at £150 a week) in place of a hospital bed (at £2,800 a week) while patient discharge was being organised.<sup>112</sup> Others have reported that early intervention through the integration of health, housing and social-care services has saved the NHS £2.65 for every £1 spent.<sup>113</sup> Interviewees bemoaned that, despite these improvements being well-known, the commissioning framework – where the NHS (funded by NHS England and CCGs) and social care (funded by local authorities and private individuals) do not act together to save money overall – is not incentivised to replicate these approaches across the country.

Homelessness is another area in which services are commissioned by a plethora of providers. This model fails to incentivise providers working together to prevent homelessness and thereafter prevent the deterioration of homeless people's condition. One interviewee explained, for example, that "housing is a small part of homelessness":

<sup>102</sup> Richard Humphries and Lillie Wenzel, *Options for Integrated Commissioning: Beyond Barker* (The King's Fund, 2015), 23; House of Commons Health Committee, *Public Health post-2013. Second Report of Session 2016-17*, 37.

<sup>103</sup> House of Commons Health Committee, *Public Health post-2013. Second Report of Session 2016-17*, 63.

<sup>104</sup> North Central London, *North Central London Sustainability and Transformation Plan*, 2016.

<sup>105</sup> David Hunter et al., *Evaluating the Leadership Role of Health and Wellbeing Boards as Drivers of Health Improvement and Integrated Care across England. Interim Report No. 2.*, 2015.

<sup>106</sup> David Freud, *Reducing Dependency, Increasing Opportunity: Options for the Future of Welfare to Work* (Department for Work and Pensions, 2007), 7.

<sup>107</sup> Gordon Waddell and A Kim Burton, *Is Work Good for Your Health and Well-Being?* (Department for Work and Pensions, 2006).

<sup>108</sup> House of Commons Health Committee, *Social Care, Fourteenth Report of Session 2010-12. Volume I*, 2012, 6.

<sup>109</sup> *Ibid.*, 6, 13.

<sup>110</sup> Humphries and Wenzel, *Options for Integrated Commissioning: Beyond Barker*; House of Commons Health Committee, *Social Care*.

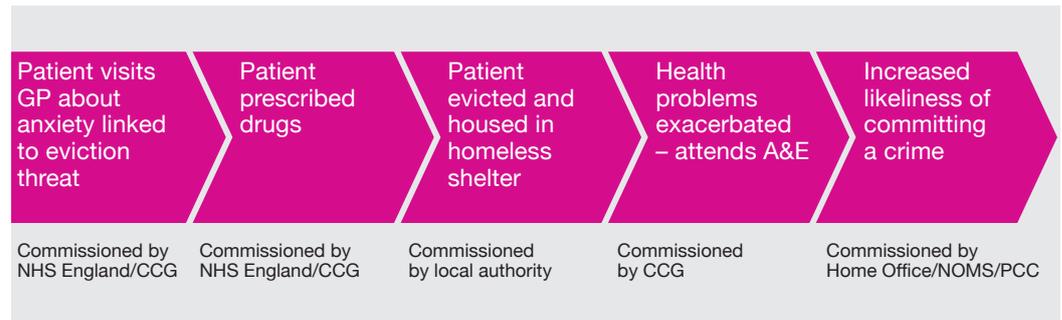
<sup>111</sup> Humphries and Wenzel, *Options for Integrated Commissioning: Beyond Barker*.

<sup>112</sup> House of Commons Health Committee, *Social Care*, 11.

<sup>113</sup> Turning Point, *Benefits Realisation: Assessing the Evidence for the Cost Benefit and Cost Effectiveness of Integrated Health and Social Care*, 2010, 9.

managing health conditions, unemployment and debts is equally important. Another interviewee pointed out that charities have separate contracts for interventions delivered for substance abuse, alcoholism and employment, rather than a single contract for “making their lives better; because that is nobody’s responsibility.” This means that no provider is incentivised to intervene at the earliest possible opportunity (see Figure 10).

**Figure 10: Journey of a patient who becomes homeless**



This is not only bad for the user (homelessness has been increasing since 2009),<sup>114</sup> it also creates huge costs for the rest of the system. The number of visits to A&E and hospital is four times higher for homeless people than the general population, despite also visiting GPs 1.5 to 2.5 times more often than the general population (and 90 per cent being registered with a GP).<sup>115</sup> Shelter has drawn a causal link between homelessness and crime.<sup>116</sup> In 2010, academics estimated that one fifth of homeless people (around 10,000) had committed “imprisonable offences” to spend a night in a police cell.<sup>117</sup> Despite these costs being incurred by the police, the Home Office plays a small role in the prevention of homelessness.<sup>118</sup> In total, the Government has estimated the annual cost of homelessness to the state as being up to £1 billion.<sup>119</sup>

### 3.2.3.3 Unwillingness to invest

A key element of prevention is a willingness to invest in services today, to save money in the longer term. This is difficult during austere fiscal times. Yet government has tools to smooth upfront investment across budgeting cycles. The AME-DEL switch is one means (see Figure 11). This formed the basis of the Work Programme’s invest-to-save model: in 2009 Professor Paul Gregg estimated the average cost of a Jobseeker’s Allowance claimant to be £8,000 a year,<sup>120</sup> which means that government can make many multiples of this money back over the years a claimant is returned to work. The Work Programme pays between £3,810 and £6,600 for a successful job outcome for a Job Seeker’s Allowance (JSA) claimant.<sup>121</sup> This approach has improved value for money, with DWP modelling suggesting the Department stands to spend £41 million – or 2 per cent – less on the Work Programme between 2011 and 2020 than it would have done for comparable performance on previous welfare-to-work schemes.<sup>122</sup>

<sup>114</sup> Department for Communities and Local Government, *Statutory Homelessness and Prevention and Relief Live Tables*, 2016.

<sup>115</sup> Homeless Link, *The Unhealthy State of Homelessness: Health Audit Results 2014*, 11.

<sup>116</sup> Department for Communities and Local Government, *Evidence Review of the Costs of Homelessness*, 2012, 11.

<sup>117</sup> Randeep Ramesh, ‘A Fifth of All Homeless People Have Committed a Crime to Get off the Streets’, *The Guardian*, 23 December 2010.

<sup>118</sup> The Home Office was only mentioned once in the Greater London Authority’s commissioning framework for homelessness, for example. Greater London Authority, *Rough Sleeping Commissioning Framework*, 2015, 10.

<sup>119</sup> Department for Communities and Local Government, *Evidence Review of the Costs of Homelessness*, 5. Though government recognises the methodological difficulties of costing homelessness. See: *Ibid.*, 1–3.

<sup>120</sup> Radio 4’s PM programme, ‘2009: Costs of Unemployment’, 18 February 2009.

<sup>121</sup> Department for Work and Pensions, *The Work Programme: Invitation to Tender*, 2011.

<sup>122</sup> National Audit Office, *The Work Programme*, 2014, 37.

### Figure 11: The AME-DEL switch

The AME-DEL switch refers to reclassifying expenditure to make space for upfront investment in services that will save money in the long run. Departmental Expenditure Limit (DEL) is a fixed budget that pays for buildings, staff, equipment and programmes. Within DWP, this covers Jobcentre Plus and other employment services. Annual Managed Expenditure (AME) pays for variable costs, such as debt interest, pensions and social security.

For the Work Programme, DWP moved employment-services expenditure (DEL) into AME spend, to reflect that returning people to employment would save social-security spending (and therefore future AME spend).

**Sources:** House of Commons Work and Pensions Committee, *Work Programme: Providers and Contracting Arrangements. Fourth Report of Session 2010–12, 2011*; George Selmer, 'Whatever Happened to DEL and AME?', 2 November 2015.

The AME-DEL switch is rarely used, however. It is unlikely to be used for the Work and Health Programme, despite the same principle of investing to save applying. This has resulted in concerns that the programme's £69-million annual-funding package is a missed opportunity to save government money in the longer term.<sup>123</sup>

A key barrier to investing to save is lack of Treasury support: the Work and Pensions Select Committee, for example, found that the Treasury considers AME-DEL switches too disruptive to the way it sets budgets.<sup>124</sup> One interviewee for this paper agreed that the Treasury's modelling did not allow for the risk of switching budgets. This attitude was compared to the Treasury's attitude to large infrastructure projects, such as High-Speed 2, in which an invest-to-grow business case is accepted. Others have echoed this point, noting the Government's willingness to invest in Hinkley Point.<sup>125</sup> If government fails to see the value (both economic and for people's wellbeing) of investing to save, this approach is unlikely to become a reality in public services.

### 3.2.4 Duplication of services and interactions

Fragmentation leads to different services being commissioned for the same group of people. Writing in 2010, Patrick Dunleavy estimated 20 to 35 per cent overlap in one or more local services doing the same things.<sup>126</sup> In the same year, the Treasury identified wastage of £100 billion on duplicated services, pointing, for example, to drug-addiction and alcohol-abuse cases being handled by the police, A&E, GPs, community workers and voluntary groups.<sup>127</sup> Devolution to Manchester, West Cheshire, Essex and three west London boroughs in 2013 is forecast to save £800 million over five years, mainly by reducing duplication in related public services.<sup>128</sup>

An example of duplication of service provision is found in the launch of two separate programmes to support families with multiple, related needs within four months of each other in 2012 (see Figure 12). Both programmes were targeted at a similar group of people (although families could not be attached to both programmes) and were funding similar activities.<sup>129</sup> Nevertheless, the programmes were designed as separate initiatives without joint governance or programme structures. The NAO argued: "The structure of the two programmes risks duplicating effort between providers and local authorities."<sup>130</sup>

<sup>123</sup> Department for Work and Pensions, *Umbrella Agreement for the Provision of Employment and Health Related Services (UAEHRS) Specification and Supporting Information*, 2016, 25.

<sup>124</sup> House of Commons Work and Pensions Committee, *Improving Access to Work for Disabled People, Second Report of Session 2014-15*, HC 481, 2014, 15.

<sup>125</sup> George Selmer, 'Whatever Happened to DEL and AME?', 2 November 2015.

<sup>126</sup> Patrick Dunleavy, *The Future of Joined-up Public Services* (2020 Public Services Trust, 2010).

<sup>127</sup> Andrew Grice, 'Treasury Says It Can Save £100bn by Ending Duplication of Local', *The Independent*, 6 July 2010.

<sup>128</sup> Patrick Wintour, 'Danny Alexander Aims to Save Billions by Cutting Duplication in Public Services', *The Guardian*, 21 March 2013.

<sup>129</sup> Alex Bate, *The Troubled Families Programme (England)* (House of Commons Library, 2016), 19.

<sup>130</sup> National Audit Office, *Programmes to Help Families Facing Multiple Challenges*, 2013.

**Figure 12: The Troubled Families and Families with Multiple Problems programmes**

	<b>Department for Communities and Local Government</b>	<b>Department for Work and Pensions</b>
<b>Programme</b>	Troubled Families	Families with Multiple Problems
<b>Provider</b>	Local authorities and partner agencies	Prime contractors (with referrals from local authorities)
<b>Objective</b>	To 'turn around' the lives of 120,000 troubled families between 1 April 2012 and 31 May 2015	To place 22 per cent of individuals attached to the programme between 1 January 2012 and 31 March 2015 into employment
<b>Central government budget over three years</b>	£448 million (plus local funding)	£200 million

Source: National Audit Office, *Programmes to Help Families Facing Multiple Challenges*, 2013.

Lack of co-ordinated working and information sharing can also lead to users repeating information multiple times to different providers. For example, both education and health teams within a local authority may conduct separate speech and language assessments for the same child.<sup>131</sup> This is cost-inefficient and causes inconvenience for the family and child who must undergo two assessments when only one is needed.

Faced with hard-to-navigate systems, some public-sector bodies have resorted to the stop-gap solution of commissioning care navigators.<sup>132</sup> These advise patients (particularly the elderly and people with long-term conditions) on what services are available to them and would benefit them most, among other forms of support.<sup>133</sup> While research suggests it reduces GP hours,<sup>134</sup> this would not be necessary if the system were not so complex in the first place.

Information sharing is also onerous for providers and service users. One employment-services provider visited during research for this paper explained that their programme has 90-minute meetings with users of the service to ask 139 questions relating to employment history, healthcare and criminal record. This information is part of a person's health record, but it is not shared. A survey found 31 per cent of 251 probation-service users believed the problem of repeating the same information to numerous people had worsened under the Transforming Rehabilitation reforms.<sup>135</sup> In a survey conducted in May 2015, 61 per cent of senior staff in local authorities, NHS providers and CCGs felt data protection rules hindered progress on health-and-social-care integration plans.<sup>136</sup>

Whether this is the case or not, confusion around what is allowed can heighten barriers to data sharing.<sup>137</sup> Patients have to repeat information when they are referred to different NHS providers as services are commissioned by different bodies which are not sharing data, despite being permitted to do so where there is a legitimate reason.<sup>138</sup> For example, a cancer patient may undergo the following journey:

<sup>131</sup> Ofsted, *Unknown Children – Destined for Disadvantage?*

<sup>132</sup> Age UK, "Care Navigators", Webpage, (n.d., accessed 7 December 2016).

<sup>133</sup> West Norfolk Clinical Commissioning Group, 'Care Navigators Aim to Help Patients Stay Safe and Well at Home', 2016.

<sup>134</sup> Brighton and Hove Clinical Commissioning Group and NHS England, *Prime Minister's Challenge Fund: Extending Access to General Practice*, 2014, 10.

<sup>135</sup> National Audit Office, *Transforming Rehabilitation*.

<sup>136</sup> Sophie Wilson et al., *Joining up Public Services around Local, Citizen Needs* (Institute for Government, 2015).

<sup>137</sup> Ibid.

<sup>138</sup> Information Commissioner's Office, *Data Sharing Code of Practice*, 2011; Norman Warner and Jack O'Sullivan, *Letting Go: How English Devolution Can Help Solve the NHS Care and Cash Crisis* (Reform, 2015).

**Figure 13: Journey of a cancer patient**

Poor data sharing can also result in people exploiting services. One council leader interviewed for this paper explained that some service users – such as homeless people and those with drug and alcohol problems – would unnecessarily use services, such as GPs and A&E centres. Information is not being shared to identify this group and thereby prevent this.

Elsewhere, administrative duplication is clear. In probation services, cases might be assessed by the NPS (to decide whether to pass it to the CRC) and the CRC (to decide whether to accept it).<sup>139</sup> This arises from the NPS having responsibility for high-risk offenders and the CRCs having responsibility for low and medium-risk offenders.<sup>140</sup>

<sup>139</sup> Richard Heys and Kevin Lockyer, *Local Commissioning, Local Solutions* (Reform, 2016).

<sup>140</sup> For a further discussion of the implications of this split, see: *Ibid.*

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# 4

## Localism: one size doesn't fit all

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Recent governments have put forward a range of initiatives and deals to support the decentralisation and devolution of the commissioning of public services.<sup>141</sup> These are designed to give “local areas control over the delivery of public services” to improve outcomes for service users across the country.<sup>142</sup> The recognition is that, in many instances, central design and oversight does not deliver the best value for money.

While local commissioning has the potential to deliver outcomes-based integrated services, it has not lived up to these ambitions to date. Despite the rhetoric, central control of service priorities has been extended as government has looked to deliver cost savings – inhibiting local commissioners from designing services that meet the problems of different areas. Funding targets for NHS trusts have, for example, stifled the transformation of healthcare around primary-care services. Worse, certain central commands – such as A&E waiting times – have motivated providers in some areas to act in ways that conflict with the ultimate aims of services, such as improving health. Yet, there is a trade-off between designing services for local users and centralised services that may benefit from economies of scale in back-office functions.

#### 4.1 The localism agenda

A key aim of recent governments has been to devolve power over certain public services (and economic policies) to local areas. In 2012, CCGs were legislated for and PCCs elected. Ten devolution deals were agreed across the country.<sup>143</sup> These will follow the formula of establishing combined authorities with directly elected mayors spanning multiple local-authority areas.<sup>144</sup> Headline deals in Greater Manchester and Cornwall build on two decades of devolution of powers to London and the devolved administrations of Scotland, Wales and Northern Ireland.<sup>145</sup>

The cases for and against the devolution of public services are complex. Briefly, central commissioners may be well-placed to construct standardised services – leveraging economies of scale and institutional knowledge to design services. This, proponents argue, also avoids the ‘postcode lottery’ of local commissioners designing services that vary wildly and achieve different outcomes for users.<sup>146</sup> Centralisation also avoids the question of coterminosity of services – that is, the design of integrated services within areas in which users have comparable profiles, suffer from related issues and require similar interventions to achieve positive outcomes. On the other hand, local commissioners may be best placed to design and monitor services which meet the needs of their areas, as they have closer ties with local providers and have a better understanding of local needs.<sup>147</sup> Greater Manchester and other devolution areas suggest that local bodies are easier to integrate than large Whitehall departments.<sup>148</sup>

The evidence collected for this Chapter supports the case for devolving the commissioning of public services. Most immediately this is because central control of commissioning services has not been able to meet the different needs and priorities of citizens across different geographies. Given these problems, the theoretical case for devolving powers to local areas is compelling and supported by nascent evidence from devolved commissioning. Recommendations of how best to achieve this will be put forward in a subsequent paper.

As it stands, despite government aims, the UK remains highly centralised (in terms of spending) by international standards (see Figure 14). And this is growing – rising by 2 per

141 For an overview, see: National Audit Office, *English Devolution Deals*, 2016.

142 First Secretary of the State and Leader of the House of Commons, *The Implications of Devolution for England*, 2014, 11.

143 National Audit Office, *English Devolution Deals*, 5.

144 *Ibid.*

145 Warner and O’Sullivan, *Letting Go: How English Devolution Can Help Solve the NHS Care and Cash Crisis*, 17–24.

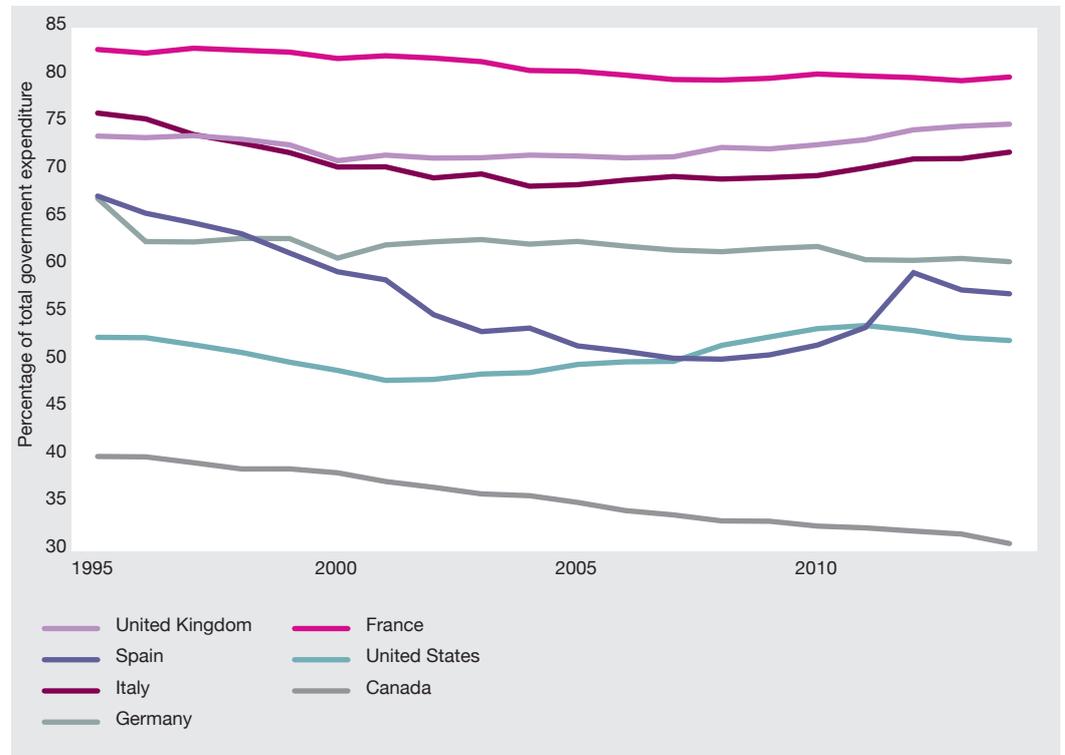
146 *Ibid.*

147 Local Government Association, *Place-Based Budgets: The Future Governance of Local Public Services*, 2010.

148 Warner and O’Sullivan, *Letting Go: How English Devolution Can Help Solve the NHS Care and Cash Crisis*.

cent between 2010 and 2014. Spending decisions have not, therefore, reflected Governments' aims to decentralise.

**Figure 14: Proportion of government expenditure spent by central government, 1995 – 2014**



Source: OECD, *Fiscal Decentralisation Database*, 2014

No single blueprint for localism across policy areas has been set out. Broad objectives include supporting and rebalancing economic growth, public-service reform and improved local accountability.<sup>149</sup> The Coalition Government's *Programme for Government* wanted to "end the era of top-down government by giving new powers to local councils, communities, neighbourhoods and individuals".<sup>150</sup> For a range of commissioned services, including criminal justice, healthcare, housing and skills support, the Coalition explained that it would, where appropriate, "decentralise commissioning to ensure greater quality and diversity."<sup>151</sup> Despite this, the Institute for Government has argued that central government has not yet reached a consensus about how much control over the design and evaluation of services local commissioning bodies should have.<sup>152</sup>

## 4.2 Variable outcomes

Even where government has claimed to have decentralised decision making in the commissioning of healthcare, criminal-justice and employment services, Whitehall has retained much control. This results in service aims driven by the centre and central decisions over where money is spent. Whilst critics of devolution point to the issue of postcode lotteries, current, highly centralised services are delivering variable outcomes because different people require different interventions to meet their needs.

<sup>149</sup> National Audit Office, *English Devolution Deals*, 5.

<sup>150</sup> HM Government, *The Coalition: Our Programme for Government*, 2010, 11.

<sup>151</sup> First Secretary of the State and Leader of the House of Commons, *The Implications of Devolution for England*, 9.

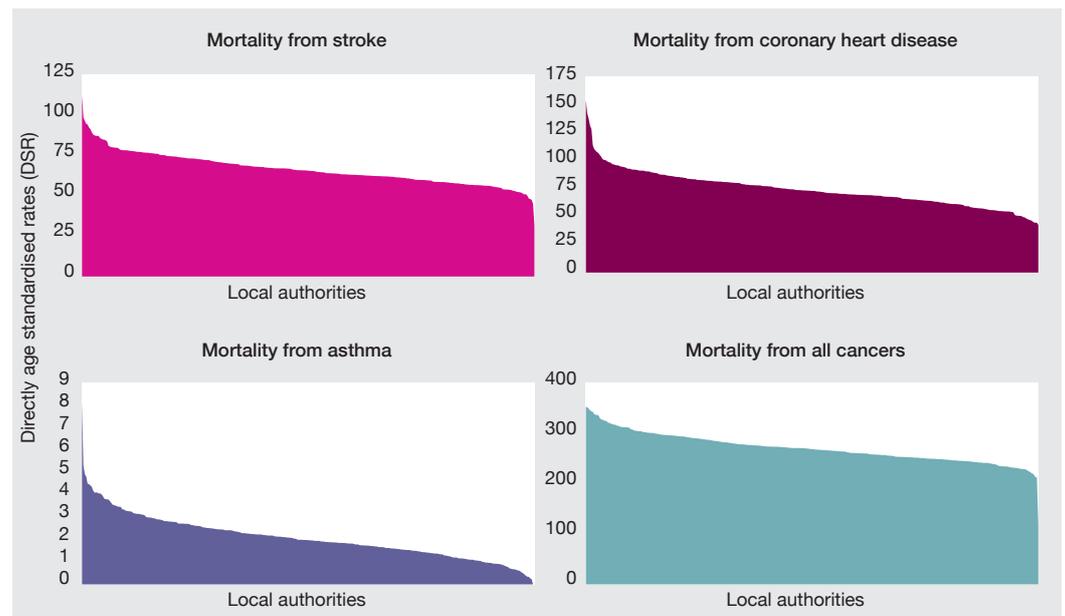
<sup>152</sup> Tom Gash, Joe Randall, and Sam Sims, *Achieving Political Decentralisation: Lessons from 30 Years of Attempting to Devolve Political Power in the UK* (Institute for Government, 2014).

### 4.2.1 Healthcare

To a degree, there will always be variation in people's health, but the way services are designed should reflect the different needs of people across the country. As it stands, despite key commissioning decisions ostensibly falling under the remit of local commissioners, central commissioners retain a high degree of control, which they are using to prioritise a short-term cost-saving agenda. This does not create the most auspicious conditions for local commissioners to design services to improve outcomes. Yet, instances where change has been delivered shows that local commissioners are not powerless to act. Both national and local commissioners are therefore failing to deliver significant reform.

Across the country, healthcare outcomes vary starkly. Infant mortality between 2011 and 2013 was four times higher in Birmingham South and Central than in Bromley.<sup>153</sup> The picture for child mortality is bleaker: the worst-performing area had mortality rates 8-times higher than the best-performing area.<sup>154</sup> Controlling for age, causes of premature death vary widely across the country (see Figure 15).

**Figure 15: Causes of premature death, by condition, 2012 – 2014 (per 100,000 population)**



Source: NHS Digital, *NHS Digital Indicator Portal*, 2015; Department of Health, *Live Well for Longer: National Support for Local Action to Reduce Premature Avoidable Mortality*, 2014.

This variation can be seen in a variety of areas in healthcare.<sup>155</sup> A driving force behind Greater Manchester designing a new approach to delivering care, for example, is that 60,000 more people are admitted to hospital than the English average would predict for long-term conditions.<sup>156</sup>

Greater Manchester's approach recognises an important reality: that environmental factors, including location and social networks, affect health more than individual circumstances, such as smoking and obesity.<sup>157</sup> These are more prevalent in different areas and so a blanket approach to designing care will contribute to variable outcomes.

<sup>153</sup> Public Health England, *Atlas of Variation in Healthcare for Children and Young People*, 2015.

<sup>154</sup> *Ibid.*

<sup>155</sup> NHS Right Care, *NHS Atlas of Variation in Healthcare*, 2015.

<sup>156</sup> Warner and O'Sullivan, *Letting Go: How English Devolution Can Help Solve the NHS Care and Cash Crisis*, 40.

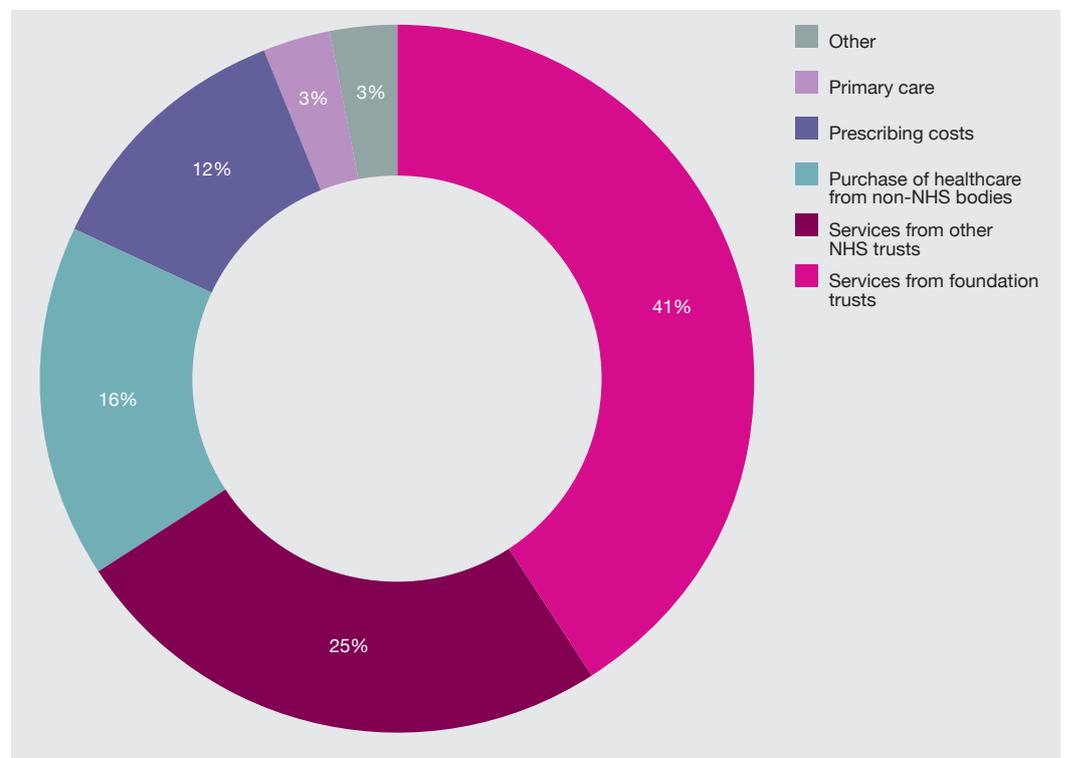
<sup>157</sup> David Buck and David Maguire, *Inequalities in Life Expectancy: Changes over Time and Implications for Policy* (The King's Fund, 2015), 11.

The Marmott Review highlighted the link between income deprivation and life expectancy across England.<sup>158</sup> Research commissioned by Public Health England subsequently showed healthcare in the north of England to be more variable than just income would predict.<sup>159</sup>

Commissioners should therefore design policies that meet the needs of their local health economies. The *Five Year Forward View* rightly calls for this. NHS Sustainability and Transformation Plans (STPs) aim to deliver this by overseeing the “transformation” of services across 44 local health economies to meet the “needs of local populations”.<sup>160</sup>

In practice this is not happening. Interviewees argued that the centre holds more control of the commissioning process than is typically recognised, which has resulted in the prioritisation of its agenda of sustainability, not transformation. Despite being commissioned by CCGs, NHS trusts (and even foundation trusts, which were designed to have more autonomy) have always “look[ed] upwards to Whitehall for direction”.<sup>161</sup> The Department of Health and regulators such as Monitor (now NHS Improvement), the King’s Fund argued, have played the largest role determining the priorities of these organisations.<sup>162</sup> One foundation-trust director recently complained of “completing assurance templates and telling people to do better because the minister told you to. This doesn’t create an awful lot of headspace to think about transformation.”<sup>163</sup> One interviewee argued that this meant CCGs were “not commissioners” – they are simply passing money from the centre to trusts, with no control over how this fits into local plans. Across the country, CCGs spend on average two-thirds of their budgets on NHS trusts and NHS foundation trusts (see Figure 16).

**Figure 16: Average operational expenditure across all 209 CCGs in England, 2015-16**



Reform calculations. NHS England, 2015-16 CCG Data Set, 2016.

158 M Marmot et al., *Fair Society, Healthy Lives: The Marmott Review. Strategic Review of Health Inequalities in England Post-2010*, 2010.

159 Margaret Whitehead, *Due North: Report of the Inquiry on Health Equity for the North* (University of Liverpool and Centre for Local Economic Strategies, 2014).

160 NHS England, “Sustainability and Transformation Plans”, Webpage (n.d., accessed 3 October 2016).

161 Ben Collins, ‘The Foundation Trust Model: Death by a Thousand Cuts’, *The King’s Fund*, 15 February 2016.

162 Ibid.

163 Jack Airey, *Local Empowerment: How to Achieve a Sustainable Health and Care System* (Localis, 2016), 13.

This central direction of how money should be spent has been entrenched as finances have deteriorated. The King's Fund describes 2016-17 financial controls as "a dramatic extension of central control."<sup>164</sup> Alongside affecting how organisations use their reserves, they provide central control over the management of staff annual leave, sick leave and deferred income.<sup>165</sup> Interviewees for this paper argued that STPs were, in the words of one, "more sustainability than transformation". This is evidenced by their emphasis on acute emergency-care deficits, which goes against plans to deliver more care in out-of-hospital settings.<sup>166</sup> A former CCG leader and former clinician interviewed for this paper diagnosed "templatitis" at the heart of STPs: documents are constructed in a way that leads them to meet central aims of money saving. Central short-term financial aims are undermining freedom for local commissioners to design plans appropriate for their area. This renders STPs a missed opportunity to take a place-based approach to healthcare design, according to a number of interviewees intimate with the process.

This is not to say that local healthcare commissioners are powerless to act. Some CCGs have delivered change – in many instances through strong leaders joining with other commissioners.<sup>167</sup> In Cornwall, CCG and NHS trust leaders and local authorities designed an integrated-care model which reduced non-elective emergency admissions for those with long-term conditions by 40 per cent between 2013 and 2014.<sup>168</sup> One interviewee described these changes as driven by "super commissioners" with the leadership to overcome a system that incentivises myopic thinking, or follow central instructions.

A key barrier to CCG leaders driving change within the current framework, several interviewees explained, is the power balance between providers and commissioners. Despite interviewees arguing that "we know what works in healthcare" – namely that more care needs to be delivered outside of hospital (a central tenet of the *Five Year Forward View*), hospital leaders and politicians have stood against hospital closures across the country.<sup>169</sup> One interviewee explained that, when pitted against recognised figures, unknown, unelected CCG leaders are unable to fight public sentiment for hospitals to remain open. Another argued that local authorities, with democratic mandates, were well-placed to articulate the benefits of new care models, but were not involved enough in the STP process. NHS England was characterised as standing in the way of locally led, transparent discussions, which could lead to more constructive decision making than the current stand-off between providers and commissioners. Although not all local authorities buy-in to this transformation, with many fighting hospital closures.<sup>170</sup>

Local commissioners would need to change drastically to deliver a step-change in healthcare delivery. Two interviewees for this paper argued that capitated budgets are "actuarially too heavy" for CCGs to design: commissioners do not have the skills to weight payments to different people and so currently rely on central government. Local commissioning bodies are, as Chapter 3 recognised, too fragmented to deliver integrated services even within healthcare. In theory, however, they are better placed than Whitehall departments to integrate, as they are smaller, less-entrenched and (in the case of Greater Manchester, at least) accustomed to working together to solve problems for the local area. Even so, questions over economies of scale of local bodies will arise (see Section 4.4).

164 Helen McKenna and Phoebe Dunn, *What the Planning Guidance Means for the NHS* (The King's Fund, 2016), 13.

165 Ibid.

166 Ewbank, Hitchcock, and Sasse, *Who Cares? The Future of General Practice*.

167 Tracey Roose, *Living Well: Pioneer for Cornwall and the Isles of Scilly. A Report to The House of Commons Health Select Committee*, 2014.

168 Ibid.

169 See, for example: Henry Bodkin, 'Street Protests Could Halt Hospital Closures - NHS Boss', *The Telegraph*, 16 November 2016; Tina Crowson, 'South Devon Hospital Closures Plan "Halt the Consultation" Say Campaigners', *Torquay Herald Express*, 2 November 2016; Nicholas Carding, 'MP Slams 24-Bed Unit Closure as Number of Patients Stuck in Hospital Rises', *Eastern Daily Press*, 30 September 2016; ITV News, 'MPs Fight against Huddersfield A&E Closure', 2 February 2016.

170 London Borough of Hammersmith and Fulham, 'Stand with Us to Fight the Latest Plan to Close Charing Cross Hospital', *LBHF*, 11 November 2016.

### 4.2.2 Reoffending

Reoffending rates have remained static for over a decade.<sup>171</sup> Reoffending ranges from 24 to 30 per cent across different English and Welsh regions.<sup>172</sup> There are a range of factors that are associated with prisoners' reoffending, combinations of which vary across different parts of the country. Important factors are truancy rates from school in childhood, in-prison attitude and behaviour, drug use, accommodation, employment, and previous offending history.<sup>173</sup> Yet, across the country, prisoners are released with differing levels of employment, accommodation and education support (see Figure 17).

**Figure 17: Variation in key predictors of reoffending upon release across England and Wales, 2014**

Region	Employment rate on discharge	Settled accommodation on release	Education/training on release rate
East Midlands	26.68%	85.36%	20.92%
East of England	33.10%	91.33%	26.59%
Greater London	23.87%	84.90%	14.83%
Kent & Sussex	27.30%	72.62%	11.37%
North East	18.42%	92.31%	14.95%
North West	35.84%	94.30%	17.76%
South Central	25.66%	84.61%	9.13%
South West	24.61%	88.11%	14.05%
Wales	19.15%	96.32%	19.55%
West Midlands	22.70%	94.34%	14.64%
Yorkshire & Humberside	21.86%	88.28%	17.92%

Source: Ministry of Justice and National Offender Management Service, *Prison and Probation Performance Statistics, 2014 to 2015*, 2015. Reform calculations.

Note: colours in each column reflect those in the bottom third of the range between regions with respect to the predictor (red); middle third (amber); and top third (green).

<sup>171</sup> Ministry of Justice, *Proven Reoffending Statistics. Quarterly Bulletin January to December 2014, England and Wales*.

<sup>172</sup> Ministry of Justice, *Geographical Data Tool, January 2014 to December 2014*, 2016.

<sup>173</sup> Brunton-Smith and Hopkins, *The Factors Associated with Proven Re-Offending Following Release from Prison: Findings from Waves 1 to 3 of Surveying Prisoner Crime Reduction*, 2.

The stubbornly high level of reoffending, coupled with no single causal factor, suggests, as the literature argues, that “a one-size-fits-all-approach [to tackling reoffending] may be inappropriate.”<sup>174</sup> Kevin Lockyer and Richard Heys have argued that reoffending remains so high in part because of a “staggering” level of central direction and control.<sup>175</sup> According to them, mandatory operating instructions – in the form of Prison Service Orders (PSOs) and Prison Service Instructions (PSIs) – handed down by central government prescribe operational issues (such as the provision of healthcare services) and spending priorities, which do not allow governors the space to deliver bespoke interventions.<sup>176</sup>

Despite the aims of policymakers, Transforming Rehabilitation contracts have struggled to incentivise probation providers to deliver tailored services to users. While established group-based approaches to reducing reoffending have been proved to work, they do not work for *all* offenders.<sup>177</sup> Yet, as the Justice Select Committee has shown, providers are not incentivised to deliver tailored approaches, as CRC-specific interventions will need to be funded by the CRC, while generic court-ordered activities are granted specific funding.<sup>178</sup> According to the Howard League for Penal Reform, this has led to “a race to the bottom in terms of service quality, with specialised, individual-focused services being decommissioned in favour of generic group activities.”<sup>179</sup>

Encouragingly, in November 2016, the Government committed to giving prison governors more control of the design of services prisons deliver.<sup>180</sup> Although one former prison governor interviewed for this paper cautioned that this required a fundamental change of approach from NOMS, which he was pessimistic about happening following NOMS’s history of strong central control of services. Nevertheless, the Ministry of Justice’s white paper recognises that central control of service design has not improved reoffending rates and provides an opportunity for reform.<sup>181</sup>

### 4.2.3 Employment services

Employment services have a clear aim: to help people move into and stay in work. The Work Programme was designed by DWP to give prime providers across 18 Contract Package Areas (CPAs) flexibility to achieve this. The ‘black-box’ model allowed providers to construct their own interventions, for which they would be paid using a PbR model that moved to 100 per cent outcomes payments during the life of the contract.<sup>182</sup>

Despite this, outcomes have varied widely across the country (see Figure 18). While four in 10 people referred to the Programme in Bracknell Forest or Horsham have achieved a job outcome, the same is true for one fifth of claimants in Dundee or Neath Port Talbot.<sup>183</sup>

174 Mentoring and Befriending Foundation, *Reducing Offending*, 2011; Scottish Government, ‘What Works to Reduce Reoffending: A Summary of the Evidence’, Research Publications, (8 May 2015).

175 Heys and Lockyer, *Local Commissioning, Local Solutions*, 32.

176 *Ibid.*

177 Public Accounts Committee, *Transforming Rehabilitation Inquiry*, 2016, 12.

178 *Ibid.*

179 Howard League for Penal Reform, “Written Evidence from the Howard League for Penal Reform”, Webpage, (28 June 2016), 1

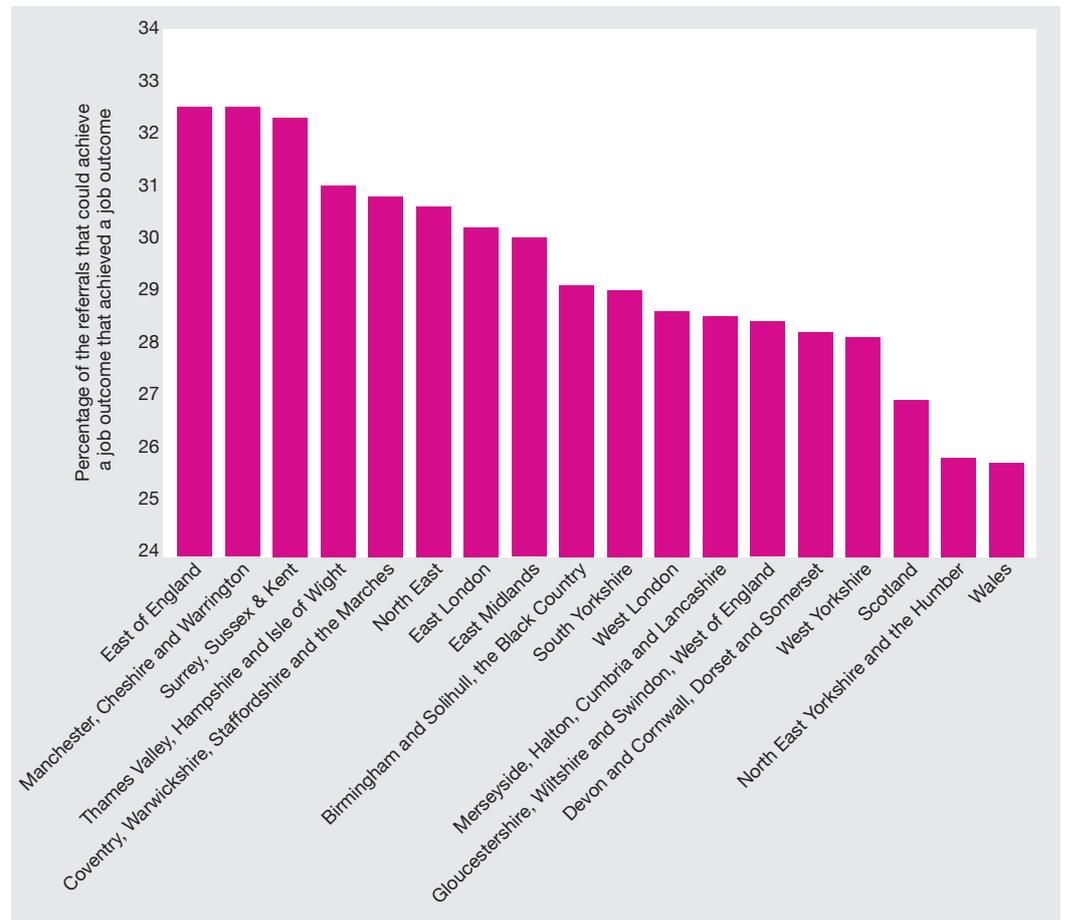
180 Ministry of Justice, *Prison Safety and Reform*.

181 *Ibid.*

182 Department for Work and Pensions, *The Work Programme*, 2014.

183 Department for Work and Pensions, *Work Programme Statistics*, 2015.

**Figure 18: Percentage of Work Programme referrals that could achieve a job outcome that did, by CPA, up to July 2015**



Source: Department for Work and Pensions, *Work Programme Statistics*, 2015.

A major reason for this variation is Whitehall's failure to create a model that reflects local labour-market conditions. IPPR has shown a strong correlation between outcomes for JSA 25+ claimants and the proportion of low-skilled jobs in a Local Enterprise Partnership area.<sup>184</sup> The reverse also holds: areas with a larger proportion of people with NVQ2+ qualifications return better job outcomes for JSA 25+ claimants.<sup>185</sup> The variation in outcomes between providers is small (at +/- two percentage points from the national average),<sup>186</sup> so IPPR has concluded that 60 percent of variation results from local economic conditions.<sup>187</sup> DWP commissioners failed to take these variations into account when procuring the Work Programme: pricing calculations were not shared with providers, local commissioners were not consulted to help build variation into DWP models and bids were accepted overwhelmingly on price – a false economy for the taxpayer as savings are delivered through a reduction in social-security payments over the medium and long term.<sup>188</sup> Interviewees for this paper explained that central commissioners were poorly placed to understand the ability of providers to deliver effective interventions in differing labour markets.

Early results from devolved employment-services programmes suggest they are on track to meet targets. Working Well, commissioned by Greater Manchester, delivered 297 of its

<sup>184</sup> Bill Davies and Luke Raikes, *Alright for Some? Fixing the Work Programme, Locally* (IPPR North, 2014).

<sup>185</sup> *Ibid.*

<sup>186</sup> *Ibid.*, 16.

<sup>187</sup> *Ibid.*, 28.

<sup>188</sup> Hitchcock, Pickles, and Riggs, *The Work and Health Programme: Levelling the Playing Field*, 17–18; Dobson, Pickles, and Tittle, *Stepping Up, Breaking Barriers. Transforming Employment Outcomes for Disabled People*.

300 job-start target in its first 18 months.<sup>189</sup> This may seem modest, but reflects the harder-to-help nature of people on the programme – ESA claimants who have been through the Work Programme. Working Well's fiscal benefit (of meeting targets) over ten years is anticipated to be £23.5 million, with a return on investment of 1:1.6.<sup>190</sup> Nevertheless, with the current target standing at 6 per cent of attachments, much work needs to be done to meet the 20-per-cent whole-programme target needed to deliver these returns.<sup>191</sup>

Anecdotal evidence collected for this paper also suggests that suppliers are positive about their relations with local commissioners. This is an important step to delivering a programme to deliver outcomes, and marks a change with how central government is viewed by many suppliers. It also bodes well for cultivating a wide base of suppliers to ensure competition in the long term, which is a key precursor to delivering value for money.<sup>192</sup>

Ninety-two per cent of these returns come from reduced ESA payments, however, which will be collected by central government.<sup>193</sup> This lack of 'buy in' for local commissioners was a concern of interviewees, who explained that local commissioners will likely spend less attention on a programme that they do not collect immediate rewards from, focusing on ones that show up on their balance sheet. Although, as *Reform* has previously argued, local commissioners would also need to bear the risk of the programme failing – that is, people not returning to work and so welfare payments continuing to be paid out – to justify them reaping the returns of helping people into work.<sup>194</sup>

This points to another value-for-money problem. DWP set a national non-intervention (or 'deadweight') level – to take into account the number of people who would return to employment without the aid of the Programme – at 5 per cent.<sup>195</sup> The NAO has criticised these calculations for assuming that economic conditions do not affect performance significantly,<sup>196</sup> and noted that some providers will therefore find it easier to meet targets than others.<sup>197</sup> Interviewees lamented that this process was paying providers for job outcomes for people who would have found a job without help. There is no barrier to central government setting different non-intervention levels – and it should be incentivised to, since it would ensure that it only pays for services that help people into work. However, Whitehall's track record does not offer comfort, and local commissioners are likely to be more incentivised to calculate non-intervention to a high degree of accuracy as differences may not revert to the mean as they could across the country.

Despite devolution deals, DWP is doing little to share commissioning power with local areas. The budget for the Work and Health Programme will be transferred to London and Greater Manchester, albeit subject to conditions including on co-funding.<sup>198</sup> The NAO has explained that in relation to the DWP, "local areas told us they had more difficulty engaging on devolution deal negotiations."<sup>199</sup> Interviewees corroborated this finding. Two local authority officials from separate areas of the country said that the DWP was reticent to cede control over key aspects of the contract, including payment structures and accountability.

189 Greater Manchester Combined Authority, *Working Well*, 2016, 36.

190 *Ibid.*, 60, 62.

191 *Ibid.*, 6.

192 Hitchcock, Pickles, and Riggs, *The Work and Health Programme: Levelling the Playing Field*, 24–25, 37–39.

193 *Ibid.*, 61.

194 Dobson, Pickles, and Tittle, *Stepping Up, Breaking Barriers. Transforming Employment Outcomes for Disabled People.*, 20–25.

195 Tom Gash et al., *Making Public Service Markets Work* (Institute for Government, 2013), 50.

196 National Audit Office, *The Work Programme*, 53.

197 National Audit Office, *The Introduction of the Work Programme*, 2012, 21.

198 HM Treasury, *Autumn Statement 2016*, 2016, 33.

199 National Audit Office, *English Devolution Deals*, 26.

### 4.3 Incentivising perverse behaviour

That different areas have different types of health needs, variable levels of crime and different labour markets should be no surprise. Designing policy in Whitehall has not only failed to meet the needs of people across the country, centrally constructed blanket targets may also incentivise providers to pursue aims that are at odds with the outcomes they should be achieving. Steven Kerr's 1975 warning of the "folly of rewarding A, while hoping for B" looms.<sup>200</sup>

A classic example is the four-hour waiting-time target in A&E. This was set out in 2000 to improve care.<sup>201</sup> Evidence supports the argument that longer emergency-department waiting times have been linked to mortality.<sup>202</sup> Yet, the target has put unnecessary pressure on clinicians to meet input targets, rather than address health needs. Hospitals who miss the target are investigated by NHS regulators,<sup>203</sup> and – despite NHS England allowing some hospitals to miss targets – A&E departments still receive negative media attention for breaching them. In the past, this has resulted in ambulances being parked outside A&E departments until staff believe they can treat them within four hours, and patients being admitted to hospital unnecessarily.<sup>204</sup> One third of doctors surveyed by the BMA had manipulated data to meet waiting targets.<sup>205</sup> This distracts clinicians from focusing on treating the needs of patients in A&E.

Targets have led to negative behaviour elsewhere. At NHS Lothian this targets-driven culture resulted in the manipulation of waiting-time data;<sup>206</sup> at NHS Mid Staffordshire a target-driven, bullying culture contributed to poor care and mortality.<sup>207</sup> The 2015 Francis report quoted an NHS worker who spoke of the "pressure to put targets over ethics".<sup>208</sup> This also raises questions over the Government's 2014 claim to have "ended prescriptive central controls and performance management."<sup>209</sup>

Targets can help focus attention on areas of concern. Their downfall, however, is in their simplicity: they assume that across the country, incentives for those providing care will mean they act in the prescribed way and deliver improvements universally.

Local commissioners are not immune from setting bad targets, however. Policing is instructive here. In 2010, the Home Secretary abolished the last centralised policing targets.<sup>210</sup> Though some forces that abandoned targets were generally positive and able to develop more bespoke performance measurements, many retained targets and some PCCs introduced extra targets, including call-handline quotas.<sup>211</sup> This points to the importance of local commissioners showing a willingness to avoid the pitfalls of rigid targets and not simply replicate central models at a local level.

Centrally set minimum-performance levels have also distorted employment-service provision. The Work Programme's funding model has been identified as leading to providers 'parking' harder-to-help claimants in favour of helping those more likely to achieve a job outcome into work. This is a process providers have readily admitted to:<sup>212</sup> a director of a prime contractor explained to the Institute for Government that "[t]hese

200 Steven Kerr, 'On the Folly of Rewarding A, While Hoping for B', *The Academy of Management Journal* 18, no. 4 (1975): 769–83.

201 Department for Health, *The NHS Plan: A Plan for Investment, A Plan for Reform*, 2000, 103.

202 Astrid Guttman et al., 'Association between Waiting Times and Short Term Mortality and Hospital Admission after Departure from Emergency Department: Population Based Cohort Study from Ontario, Canada', *BMJ* 342 (1 June 2011).

203 Joshua Taylor, 'NHS Watchdog Granted Power to Sack Arrowe Park Hospital Bosses', *Liverpool Echo*, 7 August 2015.

204 James Gubb, *Why Are We Waiting? An Analysis of Waiting Times in the NHS*, 2007, 14.

205 BBC News, 'A&E Success "Not Sustainable"', 17 January 2007.

206 David J Bowles & Associates, *Investigation into Management Culture in NHS Lothian*, 2012; BBC News, 'NHS Lothian Hospital Waiting Times "Manipulated", Report Finds', 21 March 2012.

207 Robert Francis, *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 Volume I* (The Mid Staffordshire NHS Foundation Trust Inquiry, 2010).

208 Sir Robert Francis, *Freedom to Speak Up. An Independent Review into Creating an Open and Honest Reporting Culture in the NHS*, 2015, 56.

209 First Secretary of the State and Leader of the House of Commons, *The Implications of Devolution for England*, 7.

210 Irene Curtis, *The Use of Targets in Policing*, 2015, 73.

211 *Ibid.*, 21.

212 James Rees, Adam Whitworth, and Eleanor Carter, *Support for All in the UK Work Programme? Differential Payments, Same Old Problem* (Third Sector Research Centre, 2013), 9.

contracts are on the edge of being financially viable. You have to aggressively cream and park.”<sup>213</sup> This is highlighted by the performance of the Work Programme for different claimant groups: whereas all providers outperformed expected outcomes for JSA claimants in the 12 months to March 2016, one third missed their (markedly lower) expected job outcomes for ESA ex-Incapacity Benefit claimants and almost 60 per cent missed their expected levels for JSA Prison Leavers.<sup>214</sup>

Local commissioners are better placed to set aims that matter to service users. In Cornwall and the Isles of Scilly, for example, local commissioners joined providers to design an outcomes framework focusing on goals residents deem most important.<sup>215</sup> This led to general outcomes, such as improved health and wellbeing, improved experience of care and reduced cost of care.<sup>216</sup> Focusing on patient-centred outcomes and integrating care has led to positive results: between 2013 and 2014, self-reported wellbeing improved by 23 per cent.<sup>217</sup> In contrast, Tim Harford has argued that large bureaucracies are slow to react to people's demands when designing targets, leading them to “reflect yesterday's problems not today's.”<sup>218</sup>

#### 4.4 The cost of today's framework

Commissioners must balance the ability to deliver bespoke services for local areas with administrative efficiency. Both central and local commissioning can, if managed poorly, lead to costly bureaucracy. Duplication of back-office tasks by smaller bodies will create extra costs for taxpayers; overlapping commissioning and bureaucratic control of local commissioners from the centre will similarly lead to wasted money.

The Local Government Association has previously estimated that central government spends £4.5 billion per annum on excessive regulation, overlapping funding streams and co-ordinating different areas of government.<sup>219</sup> This comprised data burdens (£400 million), Whitehall regulation, oversight and policy activity (£1 billion), and excessive non-departmental spending (£860 million).<sup>220</sup> This is before recent changes, but the sum is instructive and there is no official estimate of the cost of administering today's commissioning bodies, funding streams and oversight. At £157 million in 2015-16, the administrative spend on NOMS, for example, has more recently been questioned from a value-for-money perspective.<sup>221</sup> One interviewee pointed to the administrative burden of local organisations bidding for physical-activity funding from local authorities, DCLG and Sport England. Government should be clearer on how much administration of commissioning funding streams costs taxpayers, to enable it to accurately assess value for money.

At the other end of the spectrum, small-scale local commissioning bodies also add cost to the system through the duplication of basic functions. In 2015, the Welsh Government calculated that reducing the number of councils from 22 to eight or nine would save up to £650 million over 10 years through a reduction of administration.<sup>222</sup> CCGs across England spend large amounts of money on the administration of services from other CCGs and NHS England – a total of £301 million in 2015-16.<sup>223</sup> The money spent per head varies widely across the country – from £17 in South Reading to less than a penny in Leicester City, and Cambridgeshire and Peterborough (see Figure 19).

213 Gash et al., *Making Public Service Markets Work*, 50.

214 Reform calculations. Department for Work and Pensions, *Work Programme Statistics to December 2015*, 2016.

215 Roose, *Living Well: Pioneer for Cornwall and the Isles of Scilly. A Report to The House of Commons Health Select Committee*.

216 Ibid.

217 Ibid.

218 Tim Harford, *Messy: How to Be Creative and Resilient in a Tidy-Minded World*, 2016.

219 Local Government Association, *Delivering More for Less: Maximising Value in the Public Sector*, 2009.

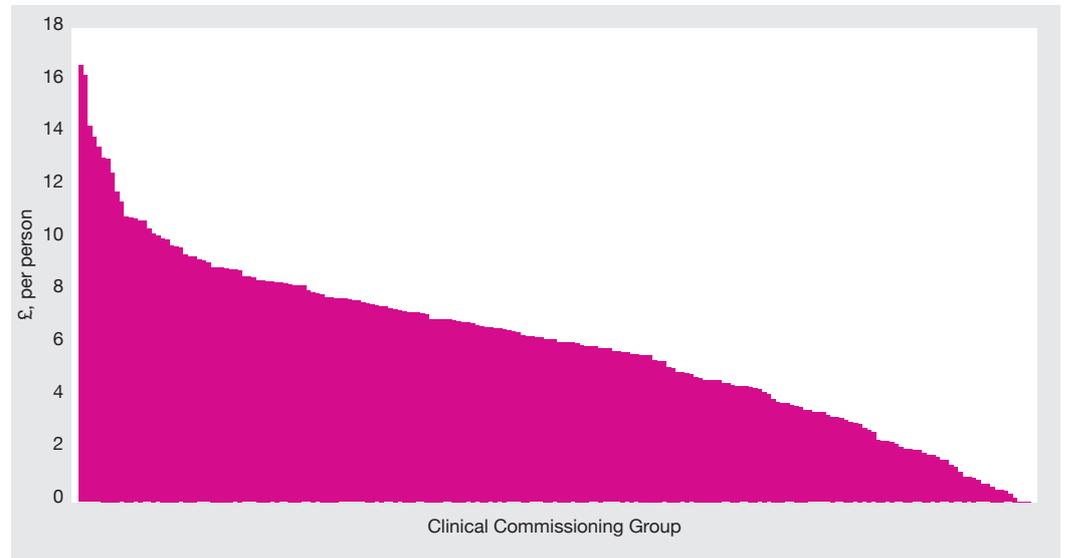
220 Ibid.

221 Heys and Lockyer, *Local Commissioning, Local Solutions*, 36.

222 'Councils Shake-up Could Save £650m, Andrews Says', *BBC News*, 24 November 2015.

223 Reform calculations. NHS England, *2015-16 CCG Data Set*, 2016; Office for National Statistics, *Mid-2015 Population Estimates for Clinical Commissioning Groups in England*, 2016.

**Figure 19: Administration costs of buying services from other CCGs and NHS England, per head**



Sources: *Reform* calculations. NHS England, 2015-16 CCG Data Set; Office for National Statistics, Mid-2015 Population Estimates for Clinical Commissioning Groups in England.

Several interviewees for this paper argued that CCG size hinders their ability to effectively design services for local citizens – also arguing that government had recognised this by suggesting just 44 STPs to cover health economies in England.<sup>224</sup> More widely, this suggests that, across key public services, government may be failing to balance the benefits of economies of scale with bodies capable of efficiently administering services tailored to the needs of local areas.

<sup>224</sup> NHS England, “Health and Care Bodies Reveal the Map That Will Transform Healthcare in England”, Webpage, (15 March 2016).

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## 5. Conclusion

Government has long held laudable aims to commission integrated services which meet the needs of users in the most efficient way. This involves targeting specific outcomes and designing services tailored to local variations. Yet, government is currently not living up to these ambitions – to the detriment of service users and taxpayers alike.

This is a critical issue because of the breadth of services government commissions third-party providers to deliver – from healthcare and housing to employment and probation services. Those receiving these services include some of the most vulnerable in society, and, in many instances, receive a wide range of assistance. Commissioning services in a way that meets their needs is critical for improving their wellbeing and life chances.

Improving people's life chances is a defined aim of the current Government.<sup>225</sup> Policymakers must also be alive to the concerns about the shape of the localism agenda – particularly regarding public services. In many ways, this holds the key to reforms to commissioning. Done well, it can provide an exciting opportunity to transform public services – delivering better outcomes for individuals, communities and the taxpayer. Forthcoming *Reform* analysis will provide a blueprint for the design of a new commissioning framework capable of delivering services that meet the complex needs of users, wherever they may live.

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225 Theresa May, 'Statement from the New Prime Minister Theresa May', Speech, (13 July 2016).

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