REFORM

Vive la devolution: devolved public-services commissioning

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The arguments and any errors that remain are the authors' and the authors' alone.

Reform

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Contents

Executive summary

Government spends over £335 billion a year on public services, including healthcare, education and public order and safety.[1] Achieving value for money is crucial for public services' sustained success. On current trajectory, the Office for Budget Responsibility argues, services are "unsustainable" in the long-term.[2]

To deliver value for money, services should be commissioned to achieve outcomes that matter to users at the lowest cost to taxpayers. Government has attempted to do this through the central commissioning of services, such as through NHS England, with 75 per cent of government expenditure currently spent by Whitehall.[3] But as *Reform*'s previous research, *Faulty by design. The state of public-service commissioning* argued, this has not achieved value for money.[4] One-sized-fits-all services fail to respond to different needs, outcomes are not rewarded and services are sometimes duplicated or missing.

A new offer is urgently needed. This paper argues that commissioning of over £100 billion of public-services spend, including 95 per cent of the NHS's budget, can be devolved to around 38 regions. International examples show that this model can deliver better outcomes at a lower cost to taxpayers.

Devolved commissioning: the story thus far

Recent governments have aimed to devolve some aspects of public-services commissioning. Eight devolution deals have been agreed across England, since the election of the first London mayor in 2000, with £7.4 billion extra funding committed over 30 years.[5] Yet, devolution of public-services commissioning has been no more than delegation. Even in devolution areas, Whitehall controls key commissioning functions, such as national contracts within Greater Manchester's healthcare devolution deal.[6]

The picture is changing slowly, however. Adult skills budgets are being devolved to give combined authorities responsibility for "allocations to providers and outcomes to be achieved".[7] The West Midlands is in talks with government about a second devolution deal.[8] The 2017 Conservative Party Manifesto aimed for "greater devolution of criminal justice responsibility and budgets to local commissioners."[9]

Local authorities interviewed for this paper expressed a desire for greater commissioning powers, in areas including healthcare, employment services, skills and offender management. Polling finds that the public is more likely to trust local authorities (79 per cent) than central government (11 per cent) to make decisions about the areas in which they live.[10] Although citizens are agnostic about the form local governance takes.[11]

1 This is calculated as domestic public services, excluding social security, defence, broader economic affairs, debt interest and EU transactions. HM Treasury, *Public Spending Statistics Release: May 2017*, 2017.
2 Office for Budget Responsibility, *Fiscal Sustainability Report 2017*, 2017.
3 OECD, *Fiscal Decentralisation Database*, 2014.
4 Eleonora Harwich, Alexander Hitchcock, and Elaine Fischer, *Faulty by Design. The State of Public-Service Commissioning.* (Reform, 2017).
5 National Audit Office, *English Devolution Deals*, 2016.
6 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*
7 Akash Paun and Maddy Thimont Jack, *Tests for the West: Devolution to the West of England* (Institute for Government, 2017).
8 Jonathan Walker, 'West Midlands Leaders Begin Negotiations with Government about Second Devolution Deal', Birmingham Mail, 24 July 2017.
9 The Conservative Party, *Forward, Together. Our Plan for a Stronger Britain and Prosperous Future. The Conservative and Unionist Party Manifesto*, 2017, 45.
10 Local Government Association and New Economy, *Learning from English Devolution Deals*, 2016.
11 Ipsos MORI and Hampshire County Council, *Serving Hampshire. Understanding the Public's Views about Possible Local Government Reorganisation in Hampshire. Final Report*, 2016.

Devolution of public services: how far can it go?

There is a strong theoretical case for commissioning services at a local level. Local commissioners are best placed to tailor services to the needs of their areas and can integrate service design to meet the multiple needs of service users. In total, this paper identifies at least £107.7 billion of annual spend that can be devolved.

English commissioners should have the financial freedom to design payment models to meet local healthcare needs – including primary, secondary and community care. People's needs differ across the country. Deaths from causes considered preventable are 41 per cent higher in the North East than South East.[12] Smoking rates are more than four times higher in Corby than Rushcliffe.[13] Other nations have delivered excellent devolved healthcare performance. Five case studies – Finland, Sweden, the Netherlands, Australia and Spain – offer comparably better outcomes in key areas. The three countries (Australia, the Netherlands and Sweden) named in the Commonwealth Fund healthcare systems performance rankings all perform better than the UK for healthcare outcomes.[14] This devolution would cover 95 per cent of 2016-17 NHS England expenditure – a total of £101.9 billion.

Employment-services commissioning can likewise tailor welfare-to-work programmes to local needs. This includes outsourced programmes, such as the Work and Health Programme, and large national programmes, such as Jobcentre Plus. Canada, Denmark, the Netherlands, the USA, as well as early experience from co-commissioning in Greater Manchester, show that locally commissioned services can achieve positive outcomes. The Government should devolve the commissioning of five employment-services programmes, totalling £1.5 billion in 2016-17.

Skills and apprenticeship commissioning could benefit from devolved commissioning. In 2016, the East Midlands employed four times as many manufacturing professionals as London.[15] Devolved commissioning of skills and apprenticeship programmes in Australia, Switzerland and Germany has helped deliver employment benefits. Government should devolve the commissioning of 12 adult skills and apprenticeship programmes, totalling £3.2 billion in 2016-17 to tailor skills programmes to local job markets.

The final focus of this paper is offender management. Reoffending costs the exchequer up to £13 billion a year.[16] Crime varies nationally: for example, London has more than twice as many drug offences as Yorkshire and the Humber.[17] Devolved commissioners are better placed to join-up currently fragmented probation programmes and tailor youth-offending programmes to local needs. Government should devolve these services, totaling £1.1 billion in 2015-16 spend.

Devolving over £100 billion of public spend should be done in a 15-year period, to follow successful international precursors. This allows legislation to be set out, municipality reform and devolution of spending functions. It would also provide local areas with clarity of what is expected from them. Areas such as Greater Manchester and London that have started down this track could receive powers sooner.

12 *Reform* analysis. Public Health England, *Public Health Outcomes Framework*, 2017.
13 *Reform* analysis. Public Health England.
14 Eric Schneider et al., *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care*, 2017.
15 *Reform* calculations. Office for National Statistics, *Population Estimates for UK, England and Wales, Scotland and Northern Ireland Mid-2016*, 2017; Office for National Statistics, *Business Register and Employment Survey 2016 (Provisional)*, 2017.
16 Home Office and Ministry of Justice, '2010 to 2015 Government Policy: Reoffending and Rehabilitation', Webpage, 8 May 2015.
17 *Reform* calculations. Office for National Statistics, *Crime in England and Wales: Police Force Area Data Tables*, 2017.

Areas of devolution: ensuring coterminosity of services

Devolved commissioning areas should be, to the greatest extent possible, areas in which people require similar interventions – that is, similar healthcare needs (because of age or lifestyle) or similar skills needs (because of local labour markets). Overlapping these boundaries achieves 'coterminosity' of service areas.[18] Achieving coterminosity makes service collaboration and integration easier, allowing commissioners to design programmes that can best meet local needs.

How these areas look will depend on what outcomes are included. This paper suggests focusing on healthcare and employment areas. It focuses on the 38 Local Enterprise Partnership areas, which could form the basis of coterminous areas with Sustainability and Transformation Partnerships and local authorities. A majority of the country would naturally fall within these boundaries, with a small number of overlapping areas, which would be subject to negotiation between local and central government. Since 80 per cent of people surveyed in 2012 felt a strong connection to their local community, policymakers should take regional identity into consideration when agreeing local commissioning areas.[19]

Skin in the game: governance models

These devolution areas require strong governance to commission services effectively. Combined authorities, of the type seen in Greater Manchester and the West Midlands, or unitary authorities, as in Cornwall, should take the commissioning functions of healthcare, employment, skills and offender-management services. This would make NHS England, CCGs and Police and Crime Commissioners redundant. Single commissioning bodies would integrate commissioning functions, allowing commissioners to design policies that improve outcomes across policy areas.

This could deliver administrative savings. EY analysis finds that moving to 27 non-metropolitan unitary authorities could save up to £2.86 billion a year. *Reform* analysis shows that NHS England, CCGs, National Offender Management Service and PCCs spent £4.63 billion on administration in 2015-16.

Single leaders should head these local commissioning bodies. Mayors are the natural option, as they provide direct democratic accountability and have proved, in the case of London and New York, that they are able to oversee large projects, such as the Olympics and public-service reform. Not all regions feel mayors suit their governance, with deals in West Yorkshire, the West of England, East Anglia and Lincolnshire disrupted because of councils' resistance to a mayor.[20] These disagreements should not scupper devolution deals, and so government should remove the election of a mayor as a red line to a devolution deal. Cornwall shows this can be achieved through a council leader atop a cabinet.

The cabinet model of governance is best placed to remove policy silos. Councillors would be responsible for general outcomes within the cabinet, with procurement officials and accountable officers working to achieve these aims within cross-silo teams. For example, mental-health-services commissioners working with employment-services commissioners to improve both outcomes through better employment.

These commissioners should oversee competitive public-service markets. The effectiveness of these are well debated, but in healthcare, employment services and offender management, outsourced models have achieved value for money. The internal market is a centre piece of the NHS and should not be eroded, as it may be with the rise

18 M. Exworthy and S. Peckham, 'The Contribution of Coterminosity to Joint Purchasing in Health and Social Care', *Health & Place* 4, no. 3 (September 1998): 234.
19 Ed Cox and Charlie Jeffrey, *The Future of England: The Local Dimension*, (IPPR, 2014), 2
20 British Academy, Governing England: Devolution and Mayors in England, 2017, 5; Stefan Pidluznyj, 'Scrapped: Lincolnshire's £450 Devolution Deal No More', The Lincolnite, 11 November 2016.

of accountable care systems in some parts of England. It should instead be refined. Contracts should be time limited, including for general practice (where only 1.3 per cent of practices were tendered in 2015 to 2016).[21] Each area could commission 3 to 4 healthcare contracts, each containing one trust and 55 GP practices. These would be valued, on average, at £755 million a year. Optimum times are dependent on policy areas, but the largest healthcare contracts should be no more than 15 years in length, with employment services and offender management optimum lengths closer to five years. Alliance contracts can allow for the integration of these policy areas.

Commissioners should also pay for outcomes, not processes. In healthcare this can be achieved through using capitated contracts (per-person funding based on individual characteristics), with the potential for some small outcomes payments, of around 10 per cent of contract value, attached for key areas identified for improvement. For employment and offender-management services, best practice in England suggests that outcomes should be at least 50 per cent of contract value to incentivise improved service delivery.

The role of the centre

Central government has a clear role to play in the devolution of public-services commissioning. It should continue to deliver a few national services. The least-commonly provided specialised health services can only achieve economies of scale if commissioned nationally. Public-health campaigns and immunisation programmes will be used across the country and so can be standardised to deliver value for money.

Whitehall should provide better clarity over the devolution of public-services commissioning. It should explain what it is willing to devolve, in clear timeframes. The Cities and Local Growth Unit fills this function currently. It should be expanded to recognise the broader public-services-commissioning devolution set out in this paper, changing its name to the “Devolution Unit”. This can also help share commissioning best practice. Support from the highest level, the Prime Minister, can help drive the devolution agenda, as George Osborne did as Chancellor of the Exchequer.

Central Government should also agree non-ring-fenced block grants for local commissioning bodies. These should be calculated based on need, with the funding formula devised by a new UK Funding Commission, which also considers the stability and fairness of funding in years ahead. The door should be left open to fiscal devolution.

Ministers should, however, set out entitlements to accessing services such as healthcare to ensure that local areas do not ration services without ministerial consent. Whitehall can also set a small number of general outcomes for commissioners to interpret locally, with no more than 25 across all public services optimal by international standards.

21 Search made in January 2017. European Union, Tenders Electronic Daily, 2017.

Recommendations

Recommendation 1: The Government should devolve 95 per cent of NHS England's budget, totalling £101.9 billion in 2016-17. The Government should scrap NHS England.

Recommendation 2: The Government should devolve responsibility for the commissioning of five employment-services programmes, including Jobcentre Plus, totalling £1.5 billion in 2016-17.

Recommendation 3: Government should devolve the commissioning of 12 skills and apprenticeships programmes, totalling £3.2 billion in 2016-17.

Recommendation 4: Government should devolve the commissioning of probation and youth-justice services, totalling £1 billion in 2015-16.

Recommendation 5: Government and local areas should ensure the coterminosity of services boundaries when entering devolution negotiations. They should take into consideration population health outcomes, their wider determinants, LEP boundaries, STP boundaries and council boundaries. Taking these elements into account would approximately result in 38 devolved commissioning areas.

Recommendation 6: A combined authority or a unitary authority should cover a commissioning area and take on all devolved commissioning functions for healthcare, employment services, skills and apprenticeships, and offender management.

Recommendation 7: Local commissioning boards should be headed by a single leader accountable for these decisions. Mayors should not be mandated by central government, however, and local areas should be able to shape their own leadership structure if one elected official holds a time-limited position accountable for public services across the local commissioning region.

Recommendation 8: Local commissioning bodies should form around the outcomes set by the cabinet and leader. Agile procurement teams should tender contracts, and disband after.

Recommendation 9: The Government should expand the role of the Cities and Local Growth Unit to include oversight of the devolution of public-services commissioning. The new unit should be called the Devolution Unit with wider membership from all departments from which powers are devolved.

Recommendation 10: Local commissioning bodies should receive block-grant funding. Local commissioning bodies should only be required to meet high-level outcomes agreed with the centre to receive the funds, and the grants should cover five-year periods. Block grants should be inflation linked and the inflation index and funding formula set by a UK Funding Commission.

Introduction

The way public services are commissioned is fundamental to their success. Commissioning is the design, procurement (where there is a purchaser-provider split) and evaluation of public services. In many cases, such as in healthcare, employment-services and offender-management programmes, this split exists, but the commissioning structures are not in place to achieve value for money for the over £335 billion spent each year on public services.[22]

This was the finding of *Reform*'s previous research, *Faulty by design. The state of public-service commissioning*, which argued that the way public services are commissioned is fundamentally flawed. Commissioners do not focus on outcomes, rather rewarding provider inputs (such as activities), or outputs (such as waiting times), rather than outcomes (such as quality-of-life improvements). The funding of services is fragmented, with different bodies commissioning services to achieve the same end (including duplicate programmes being commissioned), or gaps in services in other cases (where separate commissioners assume it is each other's responsibility). Despite aims to devolve elements of commissioning public services, to areas such as Greater Manchester, the centre still controls the design and functioning of services through national contracts and targets, for example. All together this means that commissioners have not worked with providers to tailor service design to outcomes that matter to everyone using public services.

A radical new offer is needed. The devolution agenda in England should be drastically accelerated. Commissioners need the power to design contracts for providers to meet local needs most effectively – in healthcare, employment services, skills and offender management. This requires commissioners to hold non-ring-fenced budgets, with maximum freedom to design contracts to offer to competitive public-service markets. This will only flourish if commissioning areas are designed to cover geographies requiring similar interventions, and governed by single, integrated and accountable commissioning bodies.

This is more a change of tune than a tearing up of institutional arrangements. Unitary authorities or combined authorities can be responsible for commissioning services, totaling over £100 billion in 2016-17 spend. These would replace complex local commissioning bodies, such as Clinical Commissioning Groups (CCGs) and Police and Crime Commissioners (PCCs), and allow commissioners to integrate service design. New local authority structures can cover 38 areas, which have similar healthcare and employment needs. This transfer of funding from central to local government would be followed by the abolition of NHS England, a commissioning organisation. The centre must take a light-touch approach by setting high-level outcomes, for local commissioners to tailor to their areas. International moves to a more devolved state suggest this can be completed in 15 years, with the right support.

22 This is calculated as domestic public services, excluding social security, defence, broader economic affairs, debt interest and EU transactions. HM Treasury, *Public Spending Statistics Release: May 2017*, 2017.

1 Devolved commissioning: the story thus far

In recent years, Governments have agreed devolution deals with areas across England – from Cornwall to the North East. The aim has been to stimulate economic growth and reform public services by 'devolving' control of transport, skills and, in some areas, healthcare commissioning.[23]

Devolution means a shift of control of decision-making from central government to subnational government. Control means, at the very least, policy design and aims and accountability for that policy, including through the ballot box. This entails the power to spend money in any way seen fit to achieve these aims. It may also mean the power to raise tax. Devolution is distinct from delegation, which means the transfer of administrative functions, such as executing central government's spending wishes.

Yet, to date, devolution of public-services commissioning has been no more than delegation.[24] CCGs and NHS England regional commissioners, for example, administer national GP contracts. And the devolution agenda has been largely focused on powers over economic policy, not public-service commissioning – which is design, purchase (where there is a purchaser-provider split) and evaluation of services. This not only misses the benefits of devolution to public services, but also risks failing to achieve government's aim of giving "local areas control over the delivery of public services" to improve outcomes for service users across the country.[25]

1.1 "Devolution" in the UK

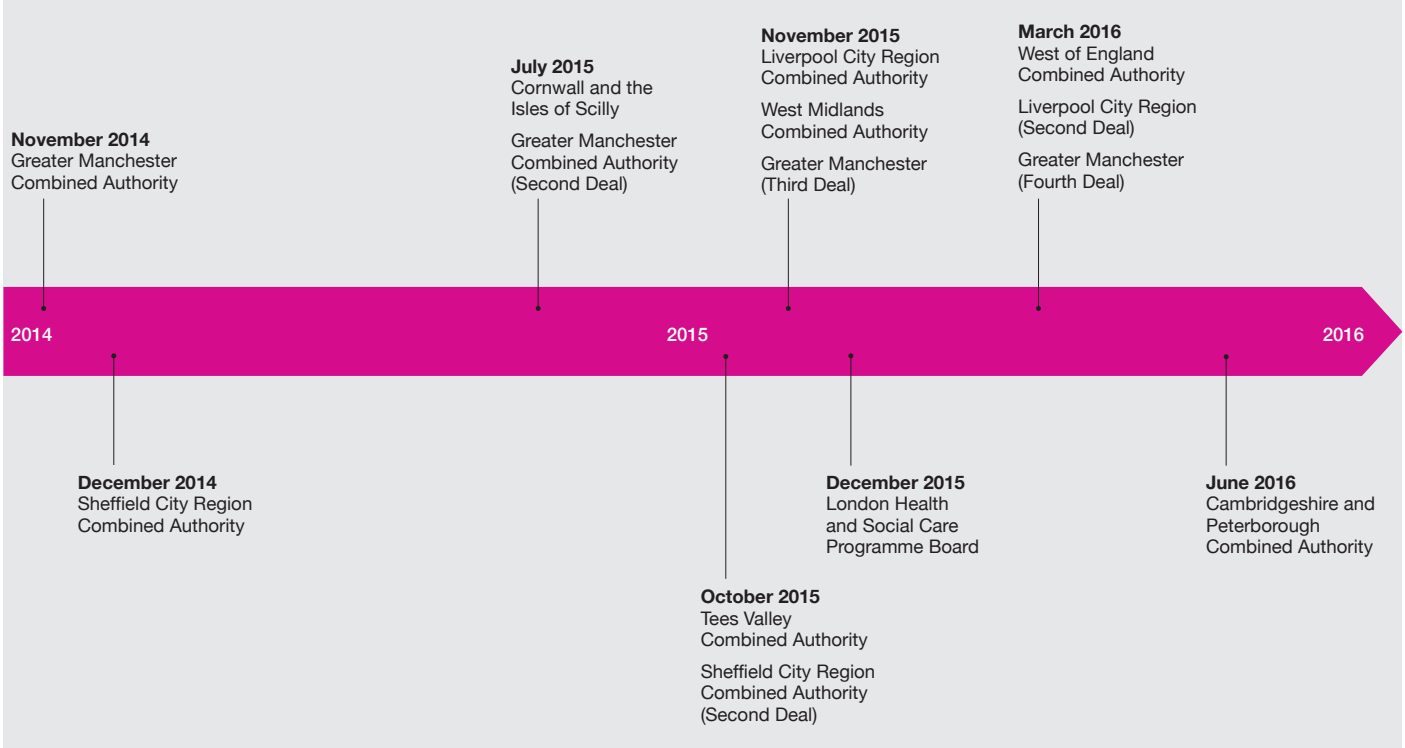
In England, eight devolution deals have been agreed since the election of the first London mayor in 2000, with £7.4 billion extra funding over a 30-year period.[26] Government recognises that population needs differ, meaning that central control has not been able to meet the different needs and priorities of citizens across England.[27] However, much of the focus has been on delivering economic growth. The first wave of deals focused on metropolitan areas with the most significant economic potential.[28] This focus ignores arguments that economic growth and public service reform are "two sides of the same coin",[29] as well as the significant potential for devolved public-service commissioning to achieve better value for money for public services (see Chapter 2).

Governments since the turn of the millennium have attempted to devolve power by legislating for devolved regions and mayors, such as the establishment of the Greater London Authority and election of the Mayor of London in 2000. Although this coincided with a growth in the proportion of government spend by central government – from 71 per cent in 2000 to 75 per cent in 2014.[30]

Since 2014, Governments have signed further devolution deals. George Osborne, as Chancellor of the Exchequer, championed headline policies such as the Northern Powerhouse in Greater Manchester (see Figure 1 and Figure 2). The original aim was to stimulate growth and productivity alongside tackling the north-south divide.[31] The Cities and Local Government Devolution Act (2016) enables devolution, but applies primarily to the core cities group.[32]

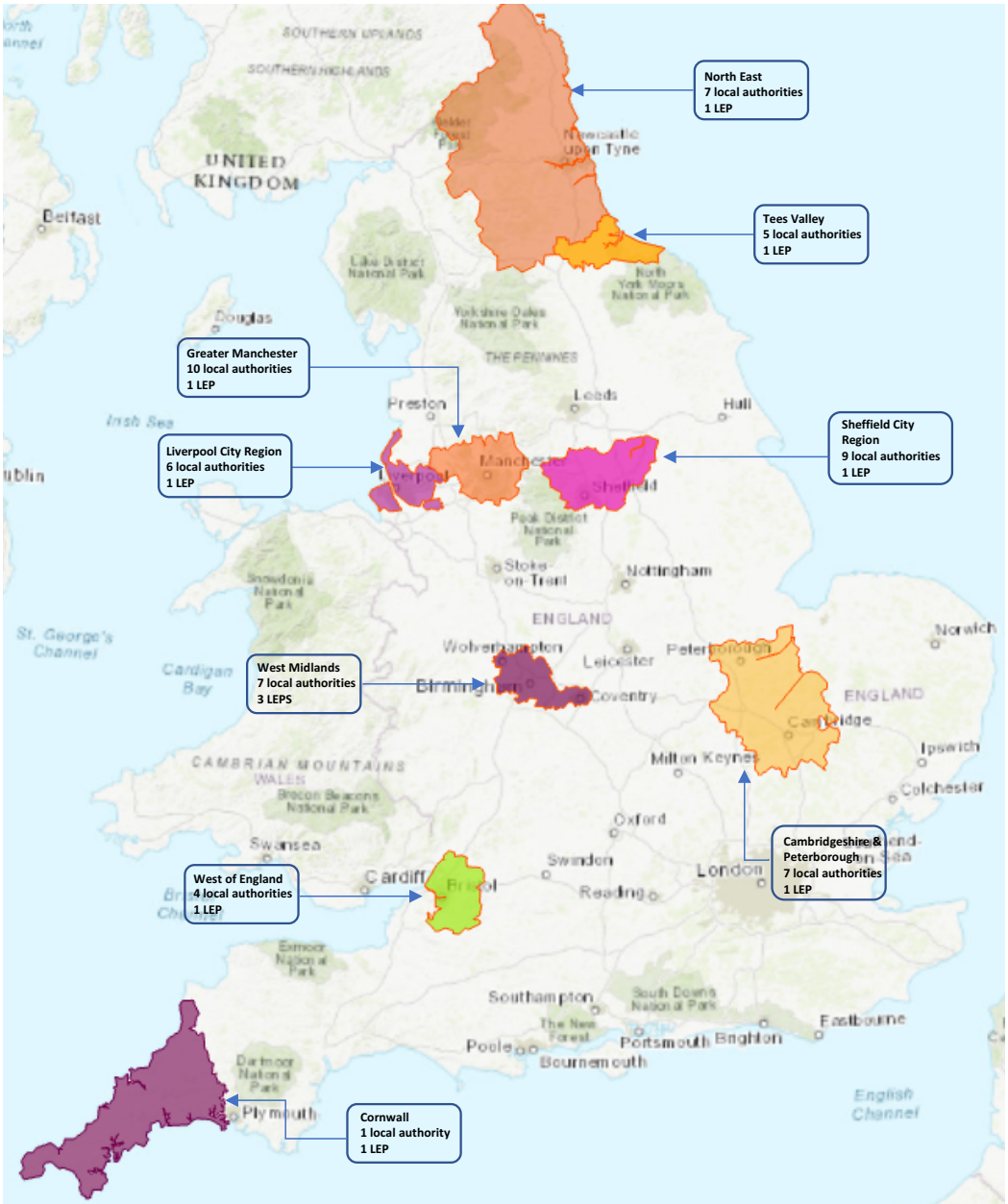
23 Joe Randall and Jo Casebourne, *Making Devolution Deals Work* (Institute for Government, 2016).
24 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*
25 First Secretary of the State and Leader of the House of Commons, *The Implications of Devolution for England*, 2014.
26 National Audit Office, *English Devolution Deals*, 2016.
27 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*
28 Randall and Casebourne, *Making Devolution Deals Work*
29 Ed Cox and Jack Hunter, *Empowering Counties: Unlocking County Devolution Deals*, 2015.
30 OECD, *Fiscal Decentralisation Database*, 2014.
31 Randall and Casebourne, *Making Devolution Deals Work*.
32 New Economics Foundation, *Understanding Devolution: A Critical Appraisal of the Greater Manchester Devolution Deal*, 2017.

Figure 1: Devolution Timeline



Source: Local Government Association, *Devolution Deals,* 2017.

Figure 2: Devolution deals to date over public-service design



Source: National Audit Office, *English Devolution Deals*, 2016, ONS Geoportal, *Combined Authorities Full Clipped Boundaries in England*, 2017, and ONS Geoportal, *Counties and Unitary Authorities Full Clipped Boundaries in England and Wales*, 2016.

While deals have differed in specific terms and functions, governments' preferred model of governance has been a combined authority with an elected mayor.[33] An exception is Cornwall, where a unitary authority, without a mayor, has received commissioning powers.[34] A combined authority is a legal body set up using national legislation that enables a group of two or more councils to collaborate and take collective decisions across council boundaries.[35] The combined authorities established tend to represent functional economic areas that reflect local labour markets and offer sufficient economies of scale.[36] These governance models have led to positive public-service outputs (see Box below).

33 National Audit Office, *Progress in Setting up Combined Authorities*, 2017.
34 Cox and Hunter, *Empowering Counties: Unlocking County Devolution Deals*.
35 Local Government Association, *Combined Authorities: A Plain English Guide*, 2016.
36 National Audit Office, *English Devolution Deals*.

Greater Manchester: outputs thus far

Councils in Greater Manchester have a long history of working together to deliver services for the area. Its devolution deal has built on this to transfer more powers to the devolution area through successive devolution deals.

Outputs include:

- Integration of health and social care, where Greater Manchester will collaborate with local NHS to administer a £6.6 billion budget.
- An evaluation framework to monitor outcomes from public-services commissioning, and to inform joint investment and planning decisions. This led to a revision of the devolved Apprenticeship Grant for Employers.[37]
- Co-commissioning with the Department for Work and Pensions (DWP) to deliver welfare-to-work services.
- Data-sharing extended across public services through GM-Connect.

Sources: Local Government Association, *Devolution Deals*, 2017; Greater Manchester Health and Social Care Partnership Strategic Partnership Board, *Enabling Health and Social Care Reform through Information*, June 2016.

In May 2017, metro mayors were elected for the first time in six English city-regions.[38] Ministers have advocated a mayor in a combined authority framework on the basis that this individual provides a single point of accountability and contact, and strategic oversight for the area.[39] Metro mayors have shown the benefits of this leadership (see, for example, Box below).

London: outcomes

London's congestion charge, introduced by Ken Livingston in 2003 resulted in modest improvements in air pollution levels and associated life expectancy.[40] Sadiq Khan's extension of the congestion charge has been praised from a public-health perspective.[41] Boris Johnson acted as a figurehead of the 2012 London Olympic Games and has been credited with ensuring London thrived "under the global spotlight".[42] The development of Stratford and Newnham areas from the games has led to new job opportunities and Newnham's council's job brokerage has helped over 30,000 people into new jobs, including people who had never worked before.[43]

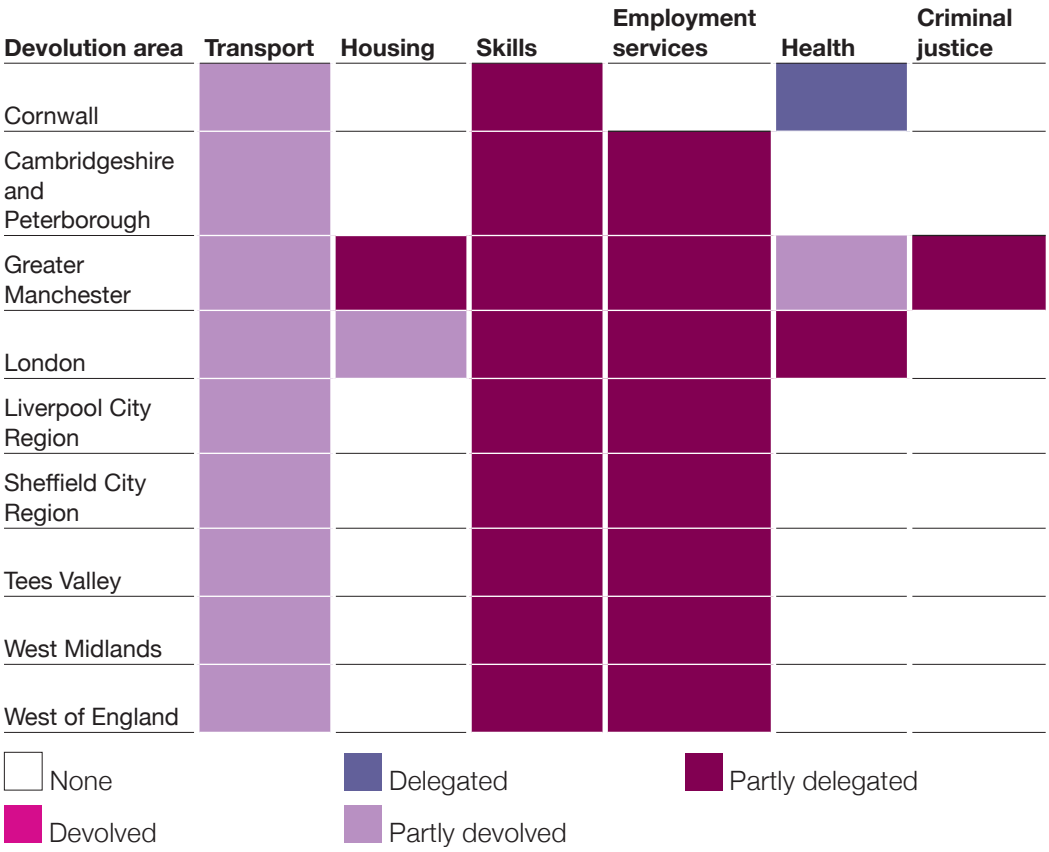
1.1.1 Moving from delegation to devolution?

The lack of a clear devolution framework from government has resulted in variations in how public-services commissioning has been devolved. Deals to date have included agreements about devolved responsibility for substantial aspects of transport, business support and further education.[44] However, there has been limited progress in health and social care, criminal justice, police and fire services and apprenticeships.[45]

37 Local Government Association and New Economy, *Learning from English Devolution Deals*, 2016.
38 British Academy, *Governing England: Devolution and Mayors in England*, 2017.
39 Ibid.
40 C. Tonne et al., 'Air Pollution and Mortality Benefits of the London Congestion Charge: Spatial and Socioeconomic Inequalities', *Occupational and Environmental Medicine* 65, no. 9 (1 September 2008): 620–27.
41 Rowena Mason, 'London to Introduce £10 Vehicle Pollution Charge, Says Sadiq Khan', *The Guardian*, 17 February 2017.
42 Asa Bennett, 'Boris Johnson's London Legacy: A Happy Megacity Loved by the World, but Not by Britain', *The Telegraph*, 6 May 2016.
43 Dave Hill, 'London Olympics Legacy: Jobs, Jobs and Jobs', *The Guardian*, 27 July 2016
44 National Audit Office, *English Devolution Deals*.
45 Ibid.

Most deals agreed are delegation not devolution (see Figure 3). Delegation is the transfer of administrative powers from central to local government, while devolution is the transfer of power over public-service design and funding to local government.

Figure 3: Commissioning control



Source: *Reform* analysis. National Audit Office, *English Devolution Deals*, 2016.

As *Faulty by Design* argues, central control of the commissioning of these services is retained either in practice through co-commissioning arrangements or through central contracts – in the case of the NHS, for example.[46] There are also tensions between local and central government for the further transfer of powers. The NAO notes that central government has rejected some devolution calls in health and social care, school-age education and fiscal devolution.[47]

Progress is being made elsewhere. Adult skills budgets are being devolved to give combined authorities responsibility for "allocations to providers and outcomes to be achieved".[48] The West Midlands is in talks with government about a second devolution deal, though the details are yet unclear.[49] People familiar with the process interviewed for this paper said that public-services commissioning is a priority for the area. All people involved in devolution regions and those at central government interviewed for this paper committed to continuing the devolution agenda, including for public-service commissioning. The 2017 Conservative Party Manifesto outlined intentions for "greater devolution of criminal justice responsibility and budgets to local commissioners."[50]

46 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*, 30–42.
47 National Audit Office, *English Devolution Deals*.
48 A Paun and M Thimont Jack, *Tests for the West: Devolution to the West of England* (Institue for Government, 2017).
49 Jonathan Walker, 'West Midlands Leaders Begin Negotiations with Government about Second Devolution Deal', Birmingham Mail, 24 July 2017.
50 The Conservative Party, *Forward, Together. Our Plan for a Stronger Britain and Prosperous Future. The Conservative and Unionist Party Manifesto*, 2017, 45.

1.2 Public desire for local decision-making

Progress on public-services-commissioning devolution is important because there is a real appetite for local control of public services. One Ipsos MORI report on devolution in Hampshire found that almost three-quarters of residents supported the principle of transferring more powers and funding to local councils.[51] Research from the Centre for Cities, the Local Government Association (LGA) and Ipsos MORI found that the public is more likely to trust local authorities (79 per cent of respondents) than central government (11 per cent of respondents) to make decisions about the areas in which they live.[52]

However, there are nuances in public opinion to consider. Other opinion polls have shown public support for devolution in all policy areas except the welfare system.[53] The same Ipsos MORI poll in Hampshire revealed that views were mixed about whether a combined authority with an elected mayor is the right model for devolution.[54] Citizens were concerned about how a mayor would be funded, and the democratic mandate.[55] This is a legitimate concern given the turnout in the recent mayoral elections, which ranged from 21.3 per cent in Tees Valley to 32.9 per cent in Cambridgeshire and Peterborough.[56] Although, turnout for the London mayoral elections in 2016 was 45.2 per cent,[57] an increase of 11 percentage points in 17 years.[58] Over time, therefore, metro mayor elections may see a similar increase in engagement.

The most successful way of communicating the devolution agenda has been using a combination of social media and more traditional methods such as town hall meetings to ensure wide appeal. For example, Cornwall council has used social media to engage the public over their devolution deal, such as their twitter campaign, #standupforcornwall.[59] Cornwall has also used traditional methods of communication, such as issuing a newsletter every eight weeks on its website to keep the public up to date on the devolution deal's progress, while local council representatives attend regional events.[60] Citizens' Assemblies have also proved effective, and in 2015 citizen assembly pilots were held in Southampton and Sheffield to debate local democracy and devolution.[61]

Continued information provision will be key to securing public buy-in to any future deals, as well as demonstrating transparency of decision making.[62] This is particularly important as devolution turns to the commissioning of public services.

51 Ipsos MORI and Hampshire County Council, *Serving Hampshire. Understanding the Public's Views about Possible Local Government Reorganisation in Hampshire. Final Report*, 2016.
52 Local Government Association and New Economy, *Learning from English Devolution Deals*.
53 Ipsos MORI, *Does the Public Back Devolution?*, 2016.
54 Ipsos MORI and Hampshire County Council, *Serving Hampshire. Understanding the Public's Views about Possible Local Government Reorganisation in Hampshire. Final Report*.
55 Ibid.
56 British Academy, *Governing England: Devolution and Mayors in England*.
57 Dan Bloom, 'London Mayor Sadiq Khan Wins the Biggest Personal Mandate in British Political History', *The Mirror*, 6 May 2016.
58 politics.co.uk, 'Mayor of London', 17 August 2017.
59 Local Government Association and New Economy, *Learning from English Devolution Deals*.
60 Ibid.
61 Matthew Flinders et al., *Democracy Matters: Lessons from the 2015 Citizens' Assemblies on English Devolution*, 2016.
62 Ipsos MORI and Hampshire County Council, *Serving Hampshire. Understanding the Public's Views about Possible Local Government Reorganisation in Hampshire. Final Report*.

2 Devolution of public-services commissioning: how far can it go?

In theory, there is a strong case for devolving the commissioning of public services. Local commissioners are best placed to design and monitor services which meet the needs of their areas, as they have closer ties with local providers and understand local needs. Local bodies may also integrate more easily to meet the multiple needs of service users.

Yet, it is not happening in practice.[63] The 2017 Conservative Party Manifesto committed to "providing clarity across England on what devolution means for different administrations so all authorities operate in a common framework."[64] The devolution of public-services commissioning must be central to this. Implementing this over a 15-year period would provide local leaders with the framework and time to achieve this devolution programme.

2.1 Areas ripe for devolution

Interviews for this paper with both central government and local authorities revealed an appetite for the devolution of public-services commissioning. Local authorities – including unitary authorities, county councils, London boroughs, city councils and combined authorities all interviewed for this paper – envisioned a radical transfer of power from Whitehall to the local area in healthcare, employment-services, skills and criminal-justice commissioning. The route it should take was debated, but the visions were clear. Senior officials from the Department for Communities and Local Government (DCLG) were open to the transfer of significant commissioning powers if proof of concepts were established.

2.1.1 Healthcare

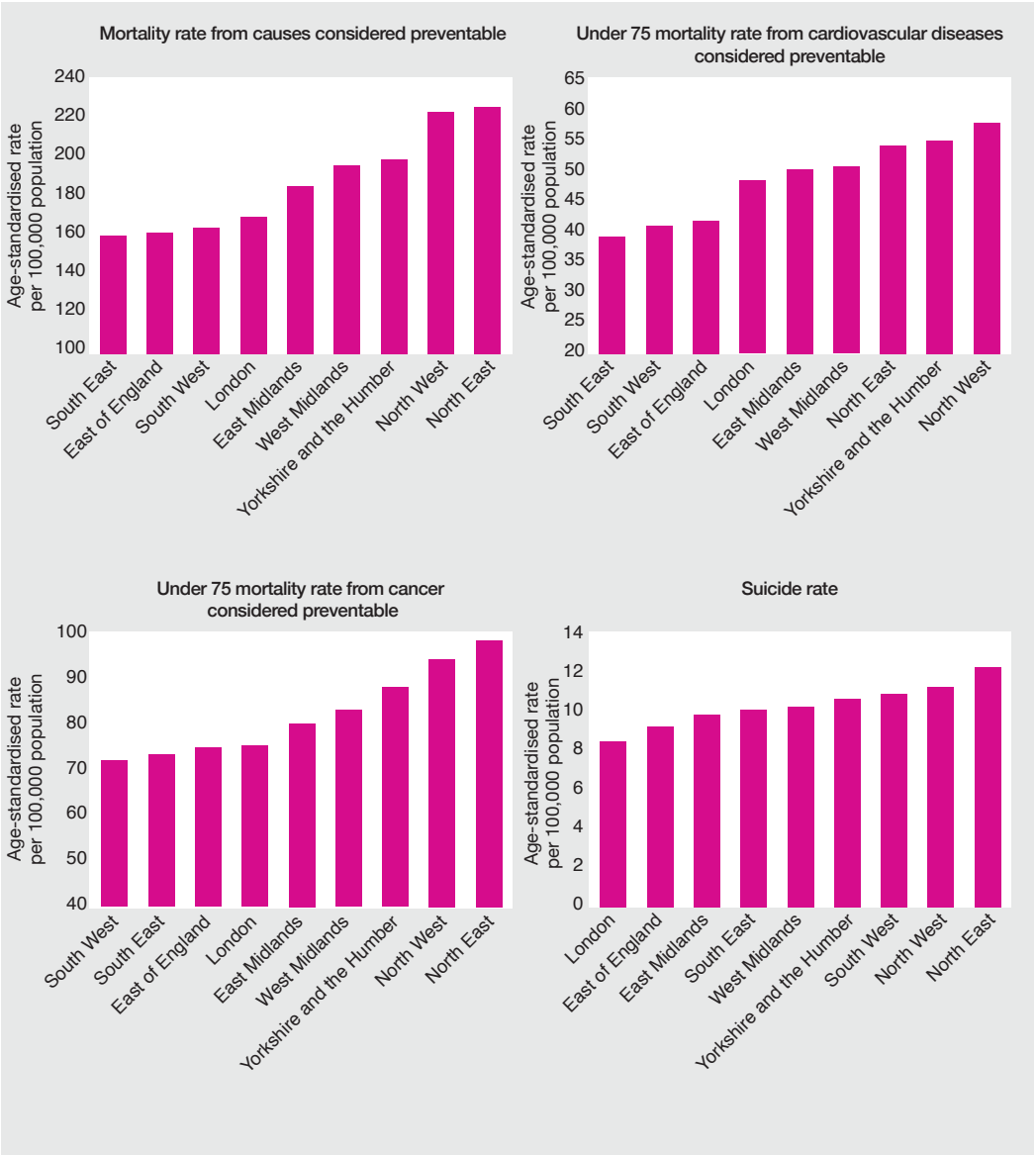
The NHS was built on Aneurin Bevan's principle that a bedpan dropping in a hospital corridor should echo in Whitehall. *Plus ça change* in 70 years: despite the creation of ostensibly local commissioning bodies, Whitehall, through NHS England, dictates policy – most notably through financial targets for trusts and national GP contracts.[65] This is despite the creation of 209 CCGs – tasked with commissioning hospital care and, increasingly, GP services – or 44 Sustainability and Transformation Partnerships (STPs) to coordinate commissioning to meet demand across the country.[66]

Local authorities, which with the right governance could take on the commissioning of healthcare services (see Chapter 4), are increasingly frustrated by the central control of healthcare. Councillors and officials from three separate local authorities interviewed for this paper disclosed that they were developing health and social-care integration plans – which the last Government tasked local authorities to do by 2020[67] – without informing the NHS with the aims of setting them in motion before NHS England could interfere or block them. One local authority interviewed for this paper received instructions from NHS England to cease with integration plans one month before they were due to be implemented. They said this rendered relation between NHS England and the local authority at an "all-time low". Interviewees from NHS England recognised that this type of central control was inhibiting devolution and integration efforts.

The principal arguments for healthcare devolution are clear. People's healthcare needs differ across the regions and so require distinct interventions. This is true for regional variations of early deaths (see Figure 4), as well as the current state of people's health (see Figure 5). In 2013, Jeremy Hunt called the variation in deaths "shocking", yet little has changed.[68] This regional view obscures the variations within regions: smoking rates are more than four times higher in Corby than Rushcliffe, for example. Preventable deaths vary by 41 per cent between the North East and South East.

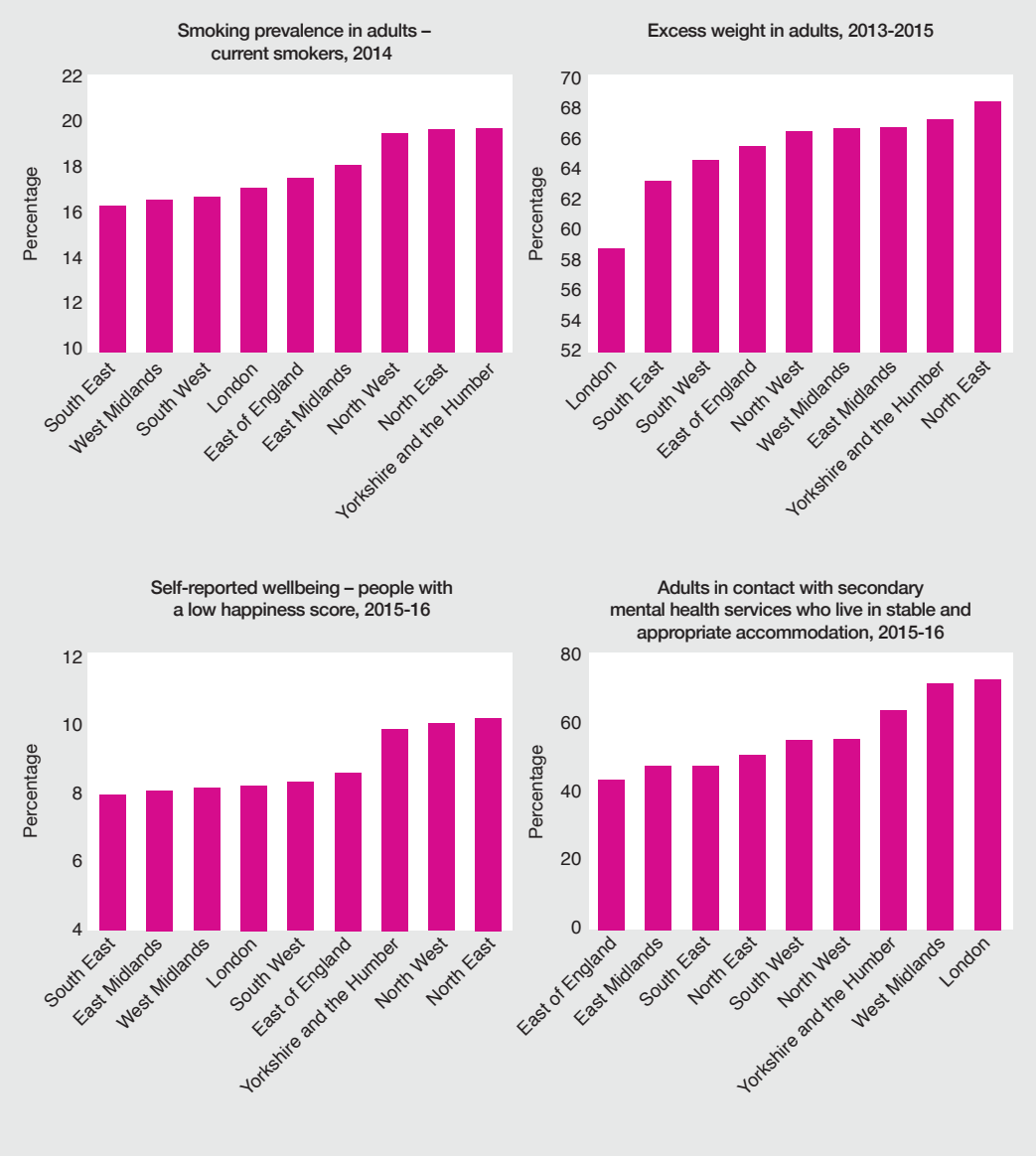
63 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*
64 The Conservative Party, *Forward, Together. Our Plan for a Stronger Britain and Prosperous Future. The Conservative and Unionist Party Manifesto*, 32.
65 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*
66 Ibid, 34-35.
67 HM Treasury, *Spending Review and Autumn Statement 2015* (HM Treasury, 2015), 1.
68 James Gallagher, 'Early Death Variations "Shocking"', BBC News, 11 June 2013.

Figure 4: Preventable deaths across England, 2013 – 2015



Source: *Reform* analysis of Public Health England, *Public Health Outcomes Framework*, 2017.

Figure 5: Variations in the health of the nation



Source: *Reform* analysis of Public Health England, *Public Health Outcomes Framework*, 2017.

Devolving commissioning functions for these areas to local commissioners, which have the power to set and incentivise outcomes and aims – including by integrating healthcare – could go a long way to enabling providers to deliver tailored care and improve outcomes.[69] Small examples, even within the current system, show the opportunities for tailoring care to local needs (see Box).

69 Wendy Ross and John Tomaney, 'Devolution and Health Policy in England', *Regional Studies* 35, no. 3 (May 2001): 265–70.

Local stroke care

To address the high number of strokes, and poor care (by international comparison), London and Greater Manchester aimed to improve care by coordinating within their regions, offering specialised hospitals, with dedicated staff to treat strokes.[70] This helped achieve a decline in mortality and length of stay in both areas.[71] The average length of stay in the capital fell from 15 days in 2009-10 to 11.5 days in 2010-11, which represented potential savings of £3.5 billion if extrapolated across England.[72]

Devolution areas can build on these successes. 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.[73] Other countries and areas show that devolved commissioning can deliver high-quality outcomes, including through integrating healthcare (see Figure 6).

Figure 6: Devolved healthcare performance

Country	Description	What has been devolved?	Performance
Finland[74]	Local authorities largely finance 21 hospital regions and have joint responsibility for health and social-care budgets. A strong emphasis on prevention. Patients can receive care anywhere in the country; local authorities commission treatments based on population need.	Primary care, secondary care, public health and social care.	Health Consumer Report described Finland as the world leader in value-for-money healthcare.[75] For a lower health expenditure as a proportion of total government expenditure, in a country with an ageing population and increasing lifestyle related chronic conditions, and similar life expectancy at birth, Finland achieves: Better maternal mortality rates, lower post-surgery mortality rates, and better five-year cancer survival rates than the UK.[76] However, mental-health outcomes are poorer in Finland than the UK, and Fins are less satisfied with their healthcare.[77]
Sweden	Health system run by elected county and municipal governments and is funded from local taxes, keeping services responsive and accountable.[78]	Primary care, secondary care, public health and social care.	In a 2017 Commonwealth Fund report, Sweden was ranked second for health outcomes amongst similar countries.[79]

70 Stephen Morris et al., 'Impact of Centralising Acute Stroke Services in English Metropolitan Areas on Mortality and Length of Hospital Stay: Difference-in-Differences Analysis', *BMJ* 349 (5 August 2014).
71 Ibid.
72 NHS London (2010), "Stroke victims in London have better access to life-saving treatment than anywhere else in the world", Press release, 19 November.
73 Norman Warner and Jack O'Sullivan, *Letting Go: How English Devolution Can Help Solve the NHS Care and Cash Crisis* (Reform, 2015), 40.
74 Edmund Stubbs, *Devolved Healthcare in Finland*, 2015.
75 Health Consumer Powerhouse, *Euro Health Consumer Index 2015*, 2015.
76 Edmund Stubbs, *The Road to Healthcare Devolution*, 2015.
77 Ibid.
78 Elliot, Bidgood, 'The Independent View: The Merits of Swedish Style Localism in Improving UK Healthcare', *Liberal Democrat Voice*, (Webpage), 22 October 2013.
79 Eric Schneider et al., *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care*, 2017.

Country	Description	What has been devolved?	Performance
Netherlands[80]	Devolution of care for frail and elderly people with long-term conditions living at home.	Community care.	Dementia villages help patients lead fuller, more autonomous lives. In Hogeweyk, reminiscence therapy has reduced the prescription drug rate by 42 per cent.[81]
Australia[82]	The state of Victoria is responsible for hospital care in the area. Health boards, of which there are 85, oversee the delivery of this care. A central health department sets out statements of priorities.	Secondary care.	The King's Fund considers Victoria as delivering the best value-for-money healthcare in Australia. Relative to other states, Victoria performs well on life-expectancy and common causes of death. Victoria has second-lowest rate amongst states for length of hospital stay.
Spain.[83]	Spain has 17 regional healthcare areas. One of which is Catalonia, with 7 million residents. In 2000, Badalona City Council integrated health and social-care commissioning to align financial incentives and deliver 'patient-centred care'. Tailored patient pathways, efficient use of all providers and multidisciplinary teams using technology were built to deliver care most effectively.	Primary care, secondary care, public health and social care.	The Regional Case Management Programme, which targets vulnerable patients, reduced GP use by 12 per cent, nurse use by 8 per cent. Emergencies were reduced by 40 per cent, non-programmed hospital admissions reduced by 56 per cent, with 23 per cent increased quality of life. The Early Discharge Programme, which delivers care in homes, reduced relapses by 28 per cent and led to a 27 per cent decreased mortality rate.

Local commissioners should have the financial freedom to design payment models to meet local healthcare needs – including primary, secondary, community care and more (see Section 4.4). Financially, central tariffs, which account for £51 billion of NHS spend a year,[84] should be replaced by local payments models that would best fit the needs of local areas. These would likely be variations of a theme to incentivise the best value care being delivered: capitated (that is per person, weighted for certain characteristics, see Section 4.4) payments for homogeneous population health economies (see Chapter 3), with targeted outcomes for specific needs.[85] These funding models would follow successful international models, which pay for care across the healthcare system, rather than splitting primary and secondary care.[86] Giving local areas the freedom to design contracts may lead to some small duplication of effort, but commissioners can share best practice, and the importance of ownership of approaches was highlighted in *Faulty by Design*,

80 Jack Airey, *Local Empowerment: How to Achieve a Sustainable Health and Care System* (Localis, 2016).
81 apolitical, 'Partnership Gives Dutch Dementia Patients an Alternative Reality', Webpage, 8 March 2017.
82 Chris Ham and Nicholas Timmins, *Managing Health Services through Devolved Governance. A Perspective from Victoria, Australia*, 2015, 6.
83 Badalona Serveis Assistencials, *Delivering Integrated Care in Badalona: Thoughts after 16 Years of Experience*, 2016.
84 *Reform* calculations. Sarah Lafond, Anita Charlesworth, and Adam Roberts, *A Year of Plenty? An Analysis of NHS Finances and Consultant Productivity*, 2017.
85 Leo Ewbank, Alexander Hitchcock, and Thomas Sasse, *Who Cares? The Future of General Practice* (Reform, 2016), 44–45.
86 Ibid.

which found that commissioners would prioritise the areas for which they have direct responsibility for spend.[87]

Local commissioners should therefore be free to allow providers to deliver care in the most effective way. This means removing central-government targets, such as A&E waiting times and entitlements, and the right to a named GP (see Chapter 5). Instead, local priorities that are outcomes focused and not input targets should guide providers (see Section 2.3) and form the basis of outcomes-focused contracts (see Section 4.4).

Devolution includes some 'specialised services', which are delivered in a small number of hospitals and used by few patients. Currently, the Government commissions 146 specialised services (through NHS England and CCGs), spending £14.6 billion a year.[88] While at least 60 of these services should continue to be commissioned by central government (to deliver economies of scale, see Section 5.1), a majority of the other 95 – costing £12 billion in 2015-16[89] – could be commissioned locally. Locally commissioning these services would allow health commissioners to incentivise joined-up care, where there is currently a split between commissioning these services and other care services that patients with long-term conditions receive. For example, patients with motor neurone disease were left without services for over a year from 2013 as the commissioning was moved from CCGs to NHS England.[90] Commissioning specialised services would further allow local commissioners to join-up care, delivering the most-appropriate treatment at the best time.

Figure 7: Proposed devolved healthcare spend (capital and resource)

Type of services	2016-17 spend
Primary care (GP services)	£7.65 billion
Secondary care (CCG budgets)	£71.85 billion
Sustainability and Transformation Fund	£2.14 billion
Specialised services	£12 billion
Other direct commissioning (dentistry, community pharmacy and ophthalmology services, public health, health and justice and armed forces)	£6.62 billion
NHS England central budgets	£1.64 billion
Total	**£101.9 billion**

Sources: NHS England, *Allocation of Resources to NHS England and the Commissioning Sector for 2016-17 to 2020-21*, 2015; NHS Digital, *Personal Social Services: Expenditure and Unit Costs. England 2015-16*, 2016.

This devolution would cover 95 per cent of 2016-17 NHS England expenditure. It would result in the redundancy of NHS England. This should be integrated into a Department of Health commissioning unit, which would commission the remaining services centrally.

There was a clear appetite for devolving healthcare commissioning responsibilities, from local authorities interviewed for this paper. As one council chief executive put it: "All local authorities will tell you that they can handle NHS commissioning; the question is whether they can achieve economies of scale individually". While not all interviewees agreed with this principle, NHS England regional commissioners and one interviewee believed local

87 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*
88 National Audit Office, *The Commissioning of Specialised Services in the NHS*, 2016, 4.
89 Ibid.
90 Ibid, 45.

authorities could take responsibility for commissioning if the appropriate geographical size and governance structures are in place (see Chapters 3 and 4).

Recommendation 1: The Government should devolve 95 per cent of NHS England's budget, totalling £101.9 billion in 2016-17. The Government should scrap NHS England.

2.1.2 Employment services

The previous Government set out an opportunity for devolved regions to take further responsibility for employment services. DWP's 2016 green paper states:

> *The government is committed to working with the devolved administrations and devolution deal areas to improve the support accessible to disabled people and people with health conditions across the country at a regional, local and community level.*[91]

Following the publication of the Government's green paper, interviewees from local government across the country referred to a lack of support from DWP for the devolution of employment-services programmes. One council Chief Executive called DWP's commissioning model – via national procurements – the "complete opposite of devolution" and argued that the Department was asking itself the question: "how can we not devolve while pretending to devolve?"

There is a compelling case for devolving employment-services commissioning. Local commissioners are better placed to understand the needs of citizens out of work in the region and are likely to better understand what providers can deliver. This means contracts can be better tailored to local needs, rather than deliver rigid approaches that are unable to account for varying 'deadweight' (of those that would have returned to work without assistance) across the country, as the DWP-commissioned Work Programme did.[92] Local commissioning may also be better placed to design contracts that reflect local labour-market variations and reward suppliers for meeting the welfare status of residents.[93] They may also design smaller contracts that promote competition to a wider pool of competitors than the current Work and Health Programme procurement, for example.[94] Most compellingly, control over employment, skills and healthcare commissioning enables local areas to design and procure integrated approaches that can better meet the demands of claimants – a prize central government has not achieved.[95]

In practice, local commissioners of employment services in other nations have delivered positive results (see Figure 8).

91 Department for Health and Department for Work and Pensions, *Improving Lives: The Work, Health and Disability Green Paper*, 2016, 19.
92 Alexander Hitchcock, Charlotte Pickles, and Alasdair Riggs, *The Work and Health Programme: Levelling the Playing Field* (Reform, 2016).
93 Bill Davies and Luke Raikes, *Alright for Some? Fixing the Work Programme, Locally* (IPPR North, 2014); Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*, 38–39.
94 Hitchcock, Pickles, and Riggs, *The Work and Health Programme: Levelling the Playing Field*; Alexander Hitchcock, 'The Work and Health Programme: Failing to Level the Playing Field', *Reformer*, 11 October 2016; Dan Finn, *Welfare to Work Devolution in England* (Joseph Rowntree Foundation, 2015), 70.
95 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*, 37–39.

Figure 8: Devolved employment-services commissioning

Place	Description	What has been devolved?	Outputs	Performance
Canada.[96]	Federalism: devolution of employment and training from 1990s, with Labour Market Development Agreements transferring funding, staff and assets to provincial governments.	Employment services for insured unemployed.	Integrated delivery of employment and training provision, social assistance.	Social assistance rates falling since 1996 and single-parent employment rate increasing.
Denmark.[97]	Municipalisation: funding and delivery of employment services devolved in 2009, preceded by reduction of municipalities from 271 to 98 to deliver services.	Employment services for all unemployed and social-assistance jobseekers.	Considerable leeway to design programmes to meet local needs.	
Greater Manchester.[98]	Co-commissioning of employment-services programme with DWP, currently being piloted.	Employment services for harder-to-help claimants.	Providers using novel approaches that have increased clients' expectations of finding work by 7.5 percentage points.	Return on investment of £1.60 for every £1 spent.
Netherlands.[99]	Municipalisation: block-grant funding for social assistance and employment services introduced for municipalities in 2004. Eligibility criteria applied for social assistance.	Employment services and benefits for social-assistance jobseekers.	Enhanced local ownership and accountability for the social assistance and freedom for municipalities to tailor employment services to local areas.	Young people kept out of the benefits system to begin with, with improved results for harder-to-help claimants following.
USA.[100]	Federalism: block grants are transferred from central to local government to assist delivery of public services, including welfare-to-work services.	Employment services and benefits for all unemployed.	States have significant discretion on how to spend money.	Support has increased the labour-market participation of single mothers, advancement for low-earners, and developing initiatives to tackle youth unemployment. However, time limiting benefits through Temporary Aid to Needy Families (to two-year lifetime limits in some states) is likely to have contributed to an increase in extreme poverty between 1996 and 2011.[101]

96 Finn, *Welfare to Work Devolution in England.*
97 The European Commission Mutual Learning Programme for Public Employment Services, *Decentralisation of Public Employment Services,* 2011.
98 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning*, 39; Matthew Ainsworth, 'Working Well' (GMCA, 2015), 36, 60, 62; Scott Dickinson, *Interim Evaluation of Working Well* (Big Life Enterprises, 2015); Laura Gardiner and Declan Gaffney, *Retention Deficit. A New Approach to Boosting Employment for People with Health Problems and Disabilities*, 2016, 41.
99 Finn, *Welfare to Work Devolution in England.*
100 Ibid.
101 Alana Semuels, 'The End of Welfare as We Know It', *The Atlantic*, 1 April 2016.

These examples suggest that the devolution agenda can go beyond specialist employment services. To match international best practice and allow local commissioners full freedom to commission services to meet the needs of all jobseekers in the area, further programmes (currently commissioned or funded by different central-government departments) could be devolved (see Figure 9).

Figure 9: Employment-services programmes which can be devolved

Programme	Current departmental sponsors	Value (2016-17)
Jobcentre Plus (JCP)	Department for Work and Pensions	£1 billion (excluding capital costs)
Work and Health Programme	Department for Work and Pensions	£69 million (2017-18)
Work and Health Unit	Department for Work and Pensions and Department of Health	£200 million
Troubled Families	Department for Communities and Local Government, Department for Education, Home Office, Department of Health, Department for Work and Pensions, Ministry of Justice	£200 million
Flexible Support Fund	Department for Work and Pensions	£64 million
Total	**Eight departments**	**£1.53 billion**

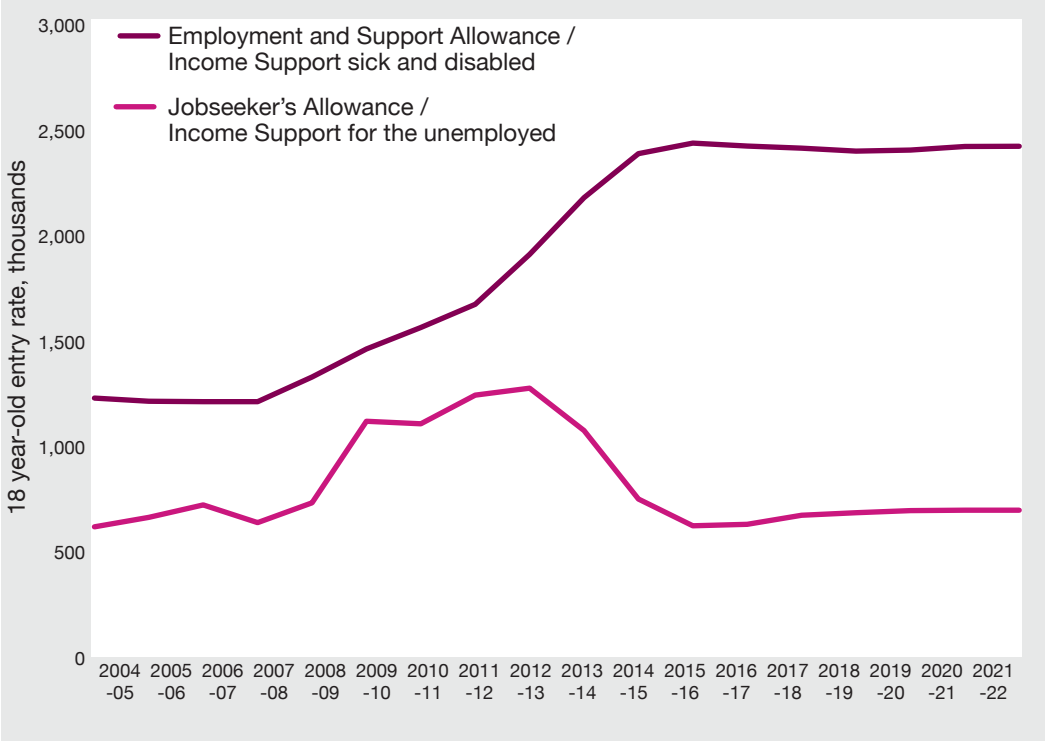
Sources: Shared Intelligence, *Is the Grass Greener…? Fragmented Funding for Growth 2016/17 – An Independent Report for the LGA*, 2016; Department for Work and Pensions, *Umbrella Agreement for the provision of Employment and Health Related Services (UAEHRS) Specification and Supporting Information*, 2016; House of Commons Work and Pensions Committee, *The Future of Jobcentre Plus. Second Report of Session 2016–17. Written Evidence from the Department for Work and Pensions (FJP0064)*, 2016.

Note: DWP's Public Finance Initiative deal on the JCP estate finishes in March 2018, after 20 years. DWP have put a tender for a framework for estates management worth £375 million, and has committed to reducing the number of JCP sites.[102]

The devolution of public-services commissioning is urgently needed as the demand for employment services changes. The current Work and Health Programme is small compared to JCP funding, but claimant caseloads have changed, requiring increased attention on those furthest from the labour market (see Figure 10).

102 Department for Work and Pensions, 'New Streamlined Jobcentre Plus Network with More Support for Jobseekers', 26 January 2017.

Figure 10: Number of people out-of-work benefits, 2004 to 2022



Source: Department for Work and Pensions, *Autumn Statement 2016 Expenditure and Caseload Forecasts*, 2016.

Due to high claimant counts and a small funding pot for the Work and Health Programme, similar claimants will likely use different services, through JCP and the Work and Health Programme. Devolving commissioning for both services would allow commissioners the freedom to use single pots of money to design programmes to meet these changing needs. Different regions would be free to commission services that meet the different needs of claimants. This may include commissioning providers capable of developing different approaches, like pioneering new technology such as online interactions – an approach that will be more appropriate in some areas of the country than others because of the range of internet use across regions amongst claimants.[103]

Devolution can be extended to other employment-services programmes. Troubled Families has a laudable aim of addressing a range of needs to help people into work, avoid criminal activity and improve mental health. However, its rigid central-government design rewarded small improvements, rather than 'turning families around' by getting people into sustained employment, as the programme sought to do.[104] Allowing local commissioners to integrate this funding into wider commissioning would enable them to target the need in the area and spend money more wisely than central government has done on families with 'multiple problems.'[105] It would also allow local areas to more accurately identify those in need: one local authority interviewed for this paper said that central government's definition of 'troubled families' only applied to three families in the area – an implausible prospect.

There is appetite amongst councils to take responsibility for commissioning employment services.[106] Local authorities interviewed for this paper explained that they would like to

103 The NAO calculates a 12-fold difference in the proportion of long-term Jobseeker's Allowance claimants who did not use the internet in the three months to Q1 2015. National Audit Office, *Memorandum for the Work and Pensions Committee. The Future of Jobcentre Plus Inquiry*, 2016.
104 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*
105 For an overview of the multiple commissioning by different central government departments of similar services, see: Ibid, 28.
106 Finn, *Welfare to Work Devolution in England*, 45.

take more responsibility for the commissioning of these services to fit with skills, employment and wider service aims. The overwhelming call was for DWP to be willing to cede control of these services, alongside designing an appropriate model of funding (see Chapter 4).

Recommendation 2: The Government should devolve responsibility for the commissioning of five employment-services programmes, including Jobcentre Plus, totalling £1.5 billion in 2016-17.

2.1.3 Skills and apprenticeships

The principle of devolving employment-services programmes holds for skills programmes. The current commissioning of apprenticeship and post-19 adult education skills is relatively straightforward: the Education and Skills Funding Agency (ESFA) funds apprenticeships and post-19 loan-funded training and education, while devolution areas have some control of post-19 Adult Skills Budget funding.[107] Yet, alongside funding for employment services through a range of the above means, with different criteria for different age groups accessing funding, overlapping provision and complexity present a barrier to value for money.[108] According to PWC, employers believe the current centralised skills system does not generate the skills needed for businesses to grow.[109]

The previous Government responded by committing to the devolution of Adult Education Skills funding to devolved regions by 2018-19.[110] The NAO has termed this "full devolution" of adult skills funding as the combined authority will be responsible for funding of providers and outcomes (to be achieved consistent with statutory requirements).[111] This is important: the Association of Colleges points out that up to one-third of devolved spend may be already committed to meeting national statutory learning entitlements and nationally mandated objectives, which leaves local areas less control over spend.[112] More recently, one commentator has argued that central government may kick skills devolution into the "very long grass".[113]

This would be a mistake. International examples of devolved skills commissioning show positive outcomes. In Australia, the government of Queensland in 2006 launched the Queensland Skills Plan, designed to involve industry in prioritising skills development areas in the region to upskill the workforce to meet demand.[114] This local approach reduced skills shortages between 2007 and 2010. In Switzerland, vocational training is administered by the 26 Cantons, which provide vocational schools, work-based training, as well as working with industry to offer apprenticeship programmes based on their needs.[115] This tailored approach, which is used by two-thirds of 15 and 16-year-olds, has contributed to Switzerland's low youth unemployment.[116]

In the UK, Institute for Government research reveals that skills devolution was the second most popular power sought after by local areas bidding for devolution deals – with 80 per cent asking for it.[117] Local commissioning will allow policymakers to work with businesses to prioritise the skills needed for local employers.[118] In 2014, 22 per cent of job vacancies

107 Association of Colleges, *The Long-Term Implications of Devolution and Localism for FE in England*, 2016, 15.
108 PwC, *Skilled for the Future. Simplifying the UK Skills System*, 2015, 4.
109 Ibid.
110 Association of Colleges, *The Long-Term Implications of Devolution and Localism for FE in England*, 17.
111 National Audit Office, *English Devolution Deals*, 20.
112 Association of Colleges, *The Long-Term Implications of Devolution and Localism for FE in England*, 18.
113 Mick Fletcher, 'Is Skills Devolution Destined for the Very Long Grass?', *NCFE*, 10 January 2017.
114 Spencer Thompson, Catherine Colebrook, and Izzy Hatfield, *Jobs and Skills in London. Building a More Responsive Skills System in the Capital* (IPPR, 2016), 35.
115 Michael Heseltine, *No Stone Unturned in the Pursuit of Growth*, 2012, 173.
116 Helena Bachmann, 'Who Needs College? The Swiss Opt for Vocational School', *Time*, 4 October 2012. 2017.
117 Jo Casebourne, 'What Have We Learned so far from the English Devo Deals Process?', The Institute for Government, 2 October 2015.
118 Core Cities, *Step 1: Boosting Skills and Jobs*, 2013, 3.

were as a result of skills shortages, up from 16 per cent in 2009.[119] Local commissioners are better placed to design programmes to fit local labour market conditions. Regionally, there are large disparities. In 2016, as a proportion of the 16+ population, London employed seven times as many finance and insurance professionals as the East Midlands, while the East Midlands employed four times as many manufacturing professionals as London (see Figure 11).

Figure 11: Industry by region, employment as percentage of 16+ population, 2016

Sources: *Reform* calculations. Office for National Statistics, *Business Register and Employment Survey 2016 (Provisional)*, 2017; Office for National Statistics, *Population Estimates for UK, England and Wales, Scotland and Northern Ireland Mid-2016*, 2017.

The ability to commission the delivery of tailored interventions takes on an increased importance as labour markets change rapidly due to technological advances, the rise of the older worker and new working practices, such as zero-hour contracts.[120] Local commissioners could devise payment-by-results models that mirror the aims of employment services to improve employment (see Chapter 4).[121] This approach would complement government's aim to improve productivity across the country and reduce unemployment.[122]

119 PwC, *Skilled for the Future. Simplifying the UK Skills System*, 4.
120 Ibid.
121 As recommended by IPPR in the context of London skills devolution. Thompson, Colebrook, and Hatfield, *Jobs and Skills in London. Building a More Responsive Skills System in the Capital*.
122 HM Treasury, *Fixing the Foundations: Creating a More Prosperous Nation*, 2015; The Conservative Party, *Forward, Together. Our Plan for a Stronger Britain and Prosperous Future. The Conservative and Unionist Party Manifesto*.

Figure 12: Skills programmes which can be devolved

Programme	Description	Current departmental sponsors	Value (2016-17)
Adult Education Budget	Education and training for adults outside of apprenticeships.	Department for Education	£1.49 billion
19+ apprenticeships	Apprenticeship funding for people aged 19 and over.	Department for Education	£926 million
Advanced Learner Loans	Loans for those aged 19 and above studying professional and technical qualifications at levels 3 to 6.	Department for Education	£260 million
National Citizen Service	Programme to develop confidence, self-awareness and responsibility amongst young people.	Cabinet Office	£200 million
Offender Learning and Skills	Employability and vocational programmes for offenders in custody.	Department for Education	£130 million
Funding to support 19+ apprenticeships	Funding to support delivery of apprenticeship programme.	Department for Education	£79 million
National Careers Service	Careers advice and resources to help people make decisions about skills and careers.	Department for Education	£77 million
Unionlearn	Learning and skills arm of the TUC.	Department for Education	£12 million
Careers and Enterprise Company	Careers education and advice for young people.	Department for Education	£5 million
Mentoring	Mentoring scheme for disadvantaged young people.	Department for Education	£3.5 million
Total		**Two departments: Department for Education; Cabinet Office**	**£3.2 billion**

Source: Shared Intelligence, *Is the Grass Greener…? Fragmented Funding for Growth 2016/17 – An Independent Report for the LGA*, 2016. Updated to reflect changes made in 2016 to sponsors of apprenticeships and skills programmes.

Devolving apprenticeship commissioning would allow local areas to ensure learning, employment and skill services work for people and employers in their local economy.[123] There has been a recent push to increase the number of apprenticeships in the UK and the introduction of the Apprenticeship levy in April 2017 could see the Government hit its target of 3 million new apprentices by 2020.[124] However, there are still fewer apprenticeships as a share of the workforce in England (11 per 1,000 employees) than other OECD countries such as Germany (40 per every 1,000 employees). Germany has the lowest unemployment rate within Europe.[125] A big reason for this is because of the Dual Vocational Training System and apprenticeships becoming highly integrated in the school and employment system. Germany's federal model allows the 16 regional governments to interpret the national legislation and agree the delivery programmes to fit local economies and characteristics.[126]

Devolved apprenticeship commissioning is important to the public. A recent poll of citizens in Liverpool and the West Midlands found that education was a top priority in both regions, with a strong emphasis on vocational training and a desire to connect businesses with schools in the region.[127] Some city deals have already put a priority focus on apprenticeships. Manchester aims to support apprenticeships in small and medium-sized enterprises (SMEs), and engage with providers in growth sectors, such as science-based apprenticeships.[128]

Recommendation 3: Government should devolve the commissioning of 12 skills and apprenticeships programmes, totalling £3.2 billion in 2016-17.

2.1.4 Offender management

The commissioning of offender-management services – including probation, youth justice and rehabilitation – has been under scrutiny in recent years. In 2004, the National Offender Management Service (NOMS) was created as an executive agency of central government to integrate management of prison and probation services. Following mixed results, it was re-launched in 2007 under the Ministry of Justice, to deliver the aims of integration and delivering cost-effective services through competition in particular.[129] NOMS commissioned the Coalition Government's flagship probation policy, Transforming Rehabilitation, through which independent providers would deliver probation services to low and medium-risk offenders across 21 regions (or Contract Package Areas), while a state-run National Probation Service (NPS) would deliver the programme for high-risk offenders.

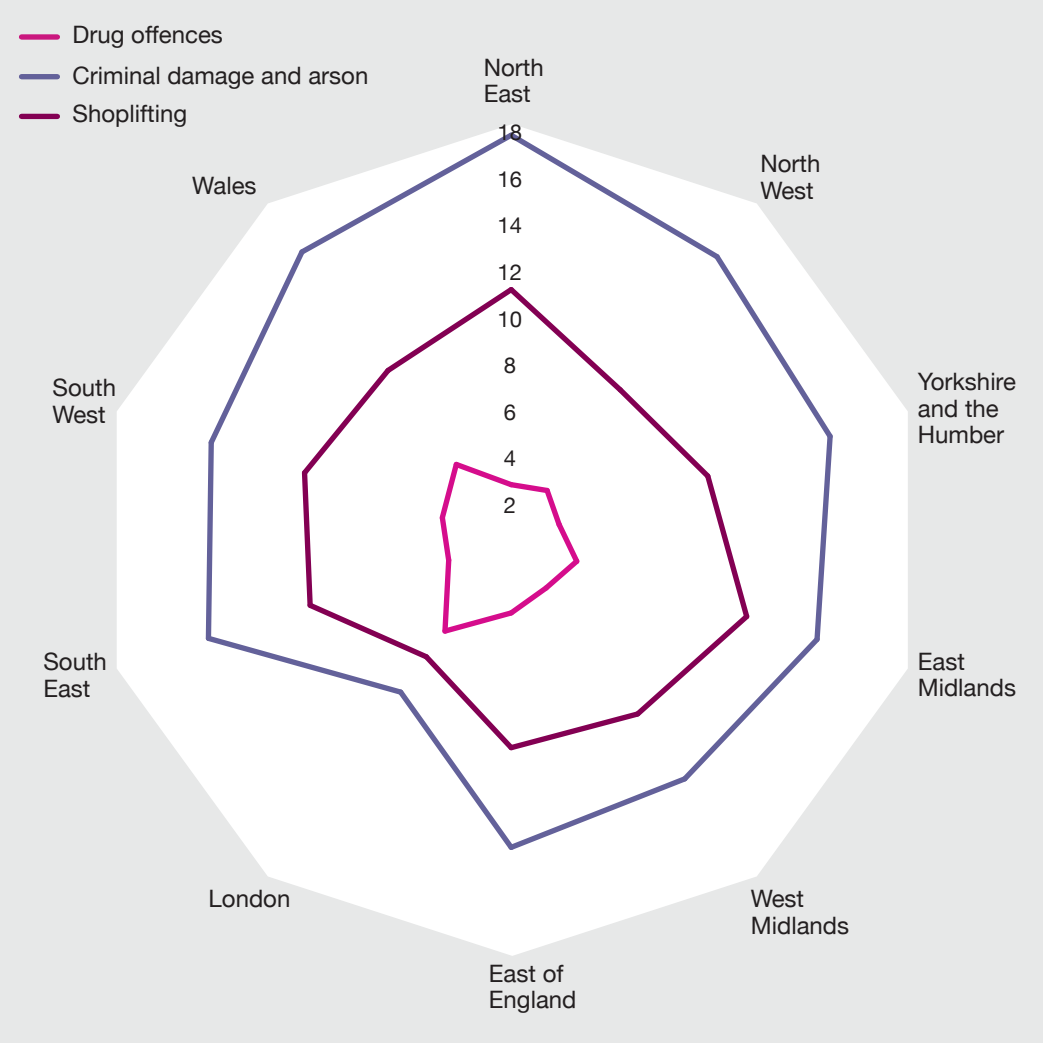
Yet reoffending has remained stubbornly high since 2004, particularly for the 60 per cent that have served short-term sentences.[130] Reoffending was estimated by government to cost the exchequer between £9.5 billion and £13 billion a year.[131] The inability to provide end-to-end services due to the split in probation-services providers, as well as the lack of incentives for those providing rehabilitation services to work with the range of services – such as employment, mental health or family – to deliver the programmes needed to meet root causes of reoffending have been identified as barriers to reducing reoffending.[132]

123 Local People: Local Growth, 2016.
124 House of Commons Library, Apprenticeship Policy in England: 2017, 2017.
125 Southampton City Council, *Appenticeships in the German System Appendix 4,* n.d.
126 Partnership for Young London, *From School to Work in London: Learning from Germany – Education and Employers Working Together*, 2015.
127 Britainthinks, *Bringing the Citizen View in the Devolution Debate*, 2016.
128 *Local Initiatives to Promote Apprenticeships in the UK: Case Studies in Manchester and Leeds*, n.d.
129 Home Office, *Reducing Crime – Changing Lives: The Government's Plans for Transforming the Management of Offenders*, 2004; Richard Heys and Kevin Lockyer, Local Commissioning, Local Solutions (Reform, 2016), 16.
130 Prison Reform Trust, *Prison: The Facts. Bromley Briefings Summer 2016*, 2016.
131 Home Office and Ministry of Justice, '2010 to 2015 Government Policy: Reoffending and Rehabilitation', Webpage, 8 May 2015.
132 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning*; Heys and Lockyer, *Local Commissioning, Local Solutions*; Marley Morris, *A Whole-System Approach to Offender Management* (IPPR, 2016).

NOMS's prescriptions have also prohibited prisons from designing programmes to help rehabilitate offenders in custody, and Transforming Rehabilitation contracts were also not designed in a way to incentivise providers from investing in rehabilitation programmes tailored to local needs.[133]

Instead the commissioning of offender-management services should be devolved to local regions, capable of prioritising approaches that meet the needs of local offender populations and work with other locally commissioned services in the area. Local commissioning could free and incentivise prisons to deliver programmes that meet the needs of the local prison population and work with other local organisations to deliver interventions that meet needs, such as employment, in a way that helps offenders back into work, for example.[134] Local approaches to contract design in Doncaster and Peterborough suggest that payment-by-results models tied to outcomes can incentivise providers to reduce reoffending in individual prisons.[135] They can also meet different needs: London has more than twice as many drug offences as a proportion of total offences than Yorkshire and the Humber, for example (see Figure 13).

Figure 13: Offences as a proportion of total offences, per cent (2015 to 2016)



Source: *Reform* calculations. Office for National Statistics, *Crime in England and Wales: Police force Area Data Tables*, April 2017

133 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning*, 36–37.
134 Heys and Lockyer, *Local Commissioning, Local Solutions*, 24.
135 Ministry of Justice, *HMP Doncaster Payment by Results Pilot: Final Process Evaluation Report*, 2015; Emma Disley et al., *The Payment by Results Social Impact Bond Pilot at HMP Peterborough: Final Process Evaluation Report* (Ministry of Justice, 2015).

Devolving the responsibility for commissioning these services would also allow commissioners to focus on the key drivers of reoffending in different regions. In 2014, employment on discharge and education on release varied by almost 100 per cent between regions.[136] As Kevin Lockyer and Richard Heys argue, local areas are best placed to commission the services to meet these demands in the community.[137] Local commissioners could also integrate the NPS and Community Rehabilitation Centres (CRCs) to ensure that offenders receive consistent probation services, as well as remove operational friction in the current approach – such as disjointed staff training and difficulties in referring cases between CRCs and NPS when risk levels are changed.[138]

Local policymakers could also coordinate approaches with police forces, which are held to account by Police and Crime Commissioners (PCCs).[139] In Durham, for example, people committing low-level offences are offered rehabilitation programmes instead of prosecution, which has reduced further crime and therefore saved offender-management service providers time and money.[140]

Manchester highlights the further possibilities of the devolution of offender-management commissioning (see Box below). The devolution of youth justice services, currently commissioned by the Youth Justice Board for England and Wales, under the Ministry of Justice, should also be devolved. As Charlie Taylor showed in a recent review of the youth-justice system, fewer children are being cautioned or convicted – down 79 per cent between 2007 and 2015.[141] This means that demand has changed within the system and those who remain are the most difficult to rehabilitate.[142] Sixty-nine per cent of those who are sentenced to custody reoffend within a year.[143] And these children are likely to suffer from several problems, including being involved in dysfunctional families, abusing drugs and alcohol and having emotional problems.[144] These are all issues which will vary across the country, requiring different responses from commissioners of services. Taylor concludes that this is best done via local programmes, delivered through a devolved administration to be tailored to local employment options.[145]

Greater Manchester offender-management deal

In 2016, Greater Manchester announced it would be taking control of some aspects of justice devolution. This includes options to devolve custody budgets for female offenders, young offenders, and those sentenced to less than two years in prison, and a "greater role" in commissioning offender management services, including a "greater say" over services that are delivered in prisons and through probation services. Greater Manchester will work with the Youth Justice Board and government to integrate youth offender management and work to redesign non-custodial youth justice funding arrangements.

Source: Greater Manchester Combined Authority, Ministry of Justice, Police and Crime Commissioner, *Greater Manchester Justice Devolution. Memorandum of Understanding*, 7 July 2016.

In total, £1 billion spent on offender-management programmes could be devolved to local commissioners (see Figure 14).

136 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*, 36.
137 Audit Commission, *Protecting the Public Purse 2014: Fighting Fraud against Local Government*, 2014.
138 Heys and Lockyer, *Local Commissioning, Local Solutions*, 26.
139 Morris, A Whole-System Approach to Offender Management, 15.
140 Morris.
141 Charles Taylor, *Review of the Youth Justice System in England and Wales* (Ministry of Justice, 2016), 3.
142 Ibid.
143 Ibid.
144 Ibid.
145 Ibid, 4.

Figure 14: Offender-management programmes which can be devolved

Programme	Description	Current departmental sponsors	Value (2015-16)
Transforming Rehabilitation (CRC and NPS)	Outsourced probation services for offenders.	Ministry of Justice	£889 million
Youth Justice Board	Body overseeing youth justice services in England and Wales.	Ministry of Justice	£165 million
Total		**One department**	**£1.05 billion**

Sources: National Audit Office, *Transforming Rehabilitation*, 2016; National Audit Office, *Departmental Overview 2015-16: Ministry of Justice*, 2016.

Recommendation 4: Government should devolve the commissioning of probation and youth-justice services, totalling £1 billion in 2015-16.

2.2 Total shift of spend

In total, this would see a dramatic shift of annual spend to local commissioners – of £107.7 billion in 2016-17 (see Figure 15).

Figure 15: Total proposed devolution of commissioning spend, 2016-17

Area	Local spend
Health	£101.9 billion
Employment services	£1.5 billion
Skills and apprenticeships	£3.2 billion
Offender management	£1.1 billion (2015-16)
Total	**£107.7 billion**

2.3 Devolved aims

Local control means setting out the aims of spending. Being unable to do this has stopped NHS commissioners from incentivising providers to deliver meaningful change.[146] This is despite health, social care and public health having headline outcome aims set by government (see Figure 16).

146 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*, 33–35.

Figure 16: Health and social-care targets

	NHS	Public health	Adult social care
Outcomes	NHS outcomes framework	Public health outcomes framework	Adult Social Care Outcomes Framework
	NHS constitution		
Outputs	Quality Outcomes Framework*	Immunisation programmes	
	Waiting times		
	Core opening hours (GPs)		
Inputs	Workforce targets	Spending targets	Spending targets
	Spending targets		

*For an explanation of why QOF does not focus on the most appropriate outcomes, please see: Leo Ewbank, Alexander Hitchcock, and Thomas Sasse, *Who Cares? The Future of General Practice* (Reform, 2016).

The same challenges are present in offender-management and employment-services programmes. Transforming Rehabilitation contracts, for example, have rewarded inputs (such as 90 per cent of contract value), rather than outcomes; and Work Programme contracts better rewarded outcomes (such as returning people to work), but struggled to tailor these to local labour markets and the expectations and skills of people in different regions.[147]

Instead, local areas should be free to set targets based on the needs of residents – with central government setting out a small number of high-level aims (see Chapter 5). This would mean more specific outcomes targets, as Greater Manchester has set under its population-health approach of 'Start Well', 'Live Well' and 'Age Well' (see Figure 17). This recognises the specific challenges that the area faces and gears policy towards meeting these.

147 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*

Figure 17: Greater Manchester health and social-care outcomes framework

	Outcome	Measure
Start Well	More children will reach a good level of development cognitively, socially and emotionally.	Improving levels of school readiness to projected England rates will result in 3,250 more children, with a good level of development by 2021.
	Fewer babies will have a low birth weight, resulting in better outcomes for the baby and less cost to the health system.	Reducing the number of low birth weight babies in Greater Manchester to projected England rates will result in 270 fewer very small babies (under 2,500 grams) by 2021.
Live Well	More families will be economically active and family incomes will increase.	Raising the number of parents in good work to the projected England average will result in 16,000 fewer children in Greater Manchester living in poverty by 2021.
	Fewer people will die early from cardio-vascular disease (CVD).	Improving premature mortality from CVD to the projected England average will result in 600 fewer deaths by 2021.
	Fewer people will die early from cancer.	Improving premature mortality from cancer to projected England average will result in 1,300 fewer deaths by 2021.
	Fewer people will die early from respiratory disease.	Improving premature mortality from respiratory disease to projected England average will result in 580 fewer deaths by 2021.
Age Well	More people will be supported to stay well and live at home for as long as possible.	Reducing the number of people over 65 admitted to hospital due to falls to the projected England average will result in 2,750 fewer serious falls.

Source: Greater Manchester Combined Authority, NHS in Greater Manchester, *Taking Charge of Our Health and Social Care in Greater Manchester*, 2016.

Tailoring outcomes to local areas could serve other policy areas. In offender management, for example, emphasising education or housing in areas which are currently falling behind the national average could lead to improved outcomes.[148] To deliver locally tailored approaches, Taylor recommends the removal of central prescription for delivering services. This includes removing the statutory duty to provide youth offending teams – to stop offending early – despite their success, as they are inhibiting the integration of youth offending with other teams in health, education and employment to deliver local approaches.[149]

This freedom to identify outcomes tailored to the region requires central government to step back from setting prescriptive targets,[150] but providing a clear outcomes framework within which local areas can confidently set more specific outcomes (see Chapter 5).

148 Ibid,Id, 36.
149 Taylor, *Review of the Youth Justice System in England and Wales*, 12.
150 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*

2.4 Timelines

A clear timeframe should be established for commissioning devolution, to benchmark progress and challenge local commissioners and government to act. International precursors and English devolution areas offer insights into the length of time devolution deals should take.

The key lesson is that deals are done in stages. Greater Manchester has had four deals; Liverpool has had two. Elsewhere, more fundamental change has been staggered. Japan moved from a highly centralised state, with thousands of fragmented municipalities, to a highly devolved country, with fiscal devolution in three broad stages over 17 years between 1993 and 2010.[151] The IPPR breaks these stages into:[152]

- **Laying the foundations** (1993 – 2000): enabling legislation for a programme for decentralisation.
- **Functional decentralisation** (2000 – 2005): scaling back of central diktats, municipality reform, devolution of central government functions.
- **Fiscal decentralisation** (2005 – 2010): transfer of some tax revenue sources and collection to local government, reform to allow local government to introduce some taxation and vary certain tax rates.

Canada's employment-services devolution took around 14 years for all provinces and territories to have the sole control of the design and delivery of programmes.[153]

These provide guidance for the timeframes for devolving public-services commissioning (see Figure 18).

151 Ed Cox, Graham Henderson, and Luke Raikes, *Decentralisation Decade* (IPPR, September 2014), 27.
152 Cox, Henderson, and Raikes.
153 Finn, Welfare to Work Devolution in England.

Figure 18: Stages for public-services devolution in England

STAGE 1: Basic devolution Five years	
Admin	**Public services**
Clarify the role and vision of central government	Adult education budget
Enabling legislation	Work and Health Programme
Design local area outcomes	Youth justice services
STAGE 2: Enhanced devolution Five years (10 years total)	
Admin	**Public services**
Redraw local government and CCG roles	NHS primary and secondary-care spending
Elect mayors/leaders	Probation
Remove central-government targets, except high-level outcomes	Further skills and employment, including Troubled Families and apprenticeships
Begin block-grant funding	
STAGE 3: Full public-services-commissioning devolution Five years (15 years total)	
Admin	**Public services**
Removal of NHS England	All healthcare
Full block-grant funding	All employment and skills services

This would give local areas and central government a 15-year window to enact full devolution of public-services commissioning. Of course, this need not be applied rigidly. Areas which are already taking some control of commissioning could be expected to complete full devolution in less time – to be agreed with central government. Setting out a timeframe for devolution can prepare areas for taking on new powers, including creating the right governance arrangements, developing the skills base and ensuring the legislation is in place to facilitate it.

3
Areas of devolution: ensuring coterminosity of services

Devolved commissioners should cover areas which have similar health, employment and skills needs. Coterminosity is the coincidence of geographical boundaries between two or more variables or organisations.[154] Currently, the commissioning of public services such as health, social care, employment, policing and offender management often does not occur within coterminous geographical boundaries. This has implications for both the delivery of outcomes-based commissioning and service integration.

3.1 The current picture

3.1.1 Problems with lack of coterminosity

The lack of a coherent overlap in geographical boundaries between public-sector commissioning bodies affects commissioners, service providers and users.[155]

The absence of coterminous boundaries between the areas covered by different commissioning bodies and providers affects their capacity to collaborate and build partnerships.[156] Despite the intended focus on health and social-care integration as laid out in the *Five Year Forward View*, the degree to which different local authorities have been included in the Sustainability and Transformation Plans process varies widely.[157] This was echoed by a councillor interviewed for this paper, who said that the *Five Year Forward View* update, made very little mention of local authorities' role in the strategy – seven times in the 71-page document.[158] The result is that the borders of certain STPs' footprints correlate poorly with local government boundaries.[159] Some local authorities operate within the framework of several STPs (see Figure 20). This creates confusion as STPs might have different priorities and ways of delivering health and social care reform.[160] The Nuffield Trust has found that commissioners, such as ambulance trusts and councils, which operate within several STP footprints, find it difficult to participate and engage during meetings with other commissioners.[161]

154 M. Exworthy and S. Peckham, 'The Contribution of Coterminosity to Joint Purchasing in Health and Social Care', *Health & Place* 4, no. 3 (September 1998): 234.
155 Paul Williams et al., *Commission on Public Service Governance and Delivery*, 2014, 32.
156 Mark Newman et al., *Commissioning in Health, Education, and Social Care: Models, Research Bibliography, and in-Depth Review of Joint Commissioning between Health and Social Care Agencies : Technical Report*, 2012, 36.
157 Jack Hunter, *Rebooting Devolution. A Common-Sense Approach to Taking Back Control* (Institute for Public Policy Research, 2017).
158 NHS England, *Next Steps on the NHS Five Year Forward View*, 2017.
159 Hunter, *Rebooting Devolution. A Common-Sense Approach to Taking Back Control*, 12.
160 Kate Laycock and Elaine Fischer, *Saving STPs. Achieving Meaningful Health and Social Care* (Reform, 2017), 9.
161 Nigel Edwards, *Sustainability and Transformation Plans: What We Know so Far* (Nuffield Trust, 2016), 15.

Figure 19: Coterminosity between STP and local authority boundaries

Light blue: Local authorities
Orange: STP

Elsewhere, the lack of coterminosity between service boundaries in the Liverpool City Region Combined Authority might, according to the NAO, "lead to complications"[162] in the commissioning and delivery of services as the devolution deals progress. The NAO warns that the absence of overlapping geographical boundaries between devolution areas and public services could lead to issues arising "around why the same CCG could be included in devolved arrangements for a combined authority but not for neighbouring local authorities."[163]

Coterminous boundaries are important when delivering services for people with multiple and complex needs, such as post-release offender management. Offenders are particularly vulnerable upon release and need to interact with multiple services such as housing, employment and health. [164] A lack of coterminosity between these service boundaries affects the ability to deliver integrated services. If service providers operate

162 National Audit Office, *Progress in Setting up Combined Authorities*, 28.
163 Ibid.
164 HM Inspectorate of Probation, *An Inspection of Through the Gate Resettlement Services for Short-Term Prisoners*, 2016, 21.

across different geographies it is difficult for them to develop a coherent strategy to address the needs of offenders. This was a central concern in the design of government's Transforming Rehabilitation strategy. CRCs were designed to draw on local expertise to design a joined-up approach to offender management. [165] The Ministry of Justice claimed that contract packages will "not cut across either PCC or local-authority boundaries and align as closely as possible with the Work Programme."[166] The intention was to facilitate integrated commissioning through coterminosity.[167] CRCs are indeed coterminous with the geographical boundaries within which PCCs operate. However, CRC boundaries do not always overlap with those of the Work Programme. The North Yorkshire, Humberside and Lincolnshire CRC, for example, spans over the North Yorkshire and East Midland Work Programme contract package areas, but is smaller than the area covered by these. This could create issues in the effectiveness of service delivery as CRCs deal with more providers.

3.2 Ensuring coterminosity

3.2.1 Benefits of coterminosity

There are several benefits for commissioners when operating within coterminous boundaries. First, collaboration and service integration is made easier. As services share geographical boundaries, fragmentation is minimised and the opportunities for collaboration between public services are increased.[168] It also facilitates communication between various commissioning bodies at a local level.[169]

Addressing the demands of populations with complex needs is more efficient.[170] For example, commissioners designing services for individuals suffering from multiple disadvantages, such as homelessness, substance misuse and mental-health issues, would all operate in the same area in a scenario where boundaries were coterminous. This would facilitate the creation of singular integrated services focused on delivering the best outcomes for the local population.[171] According to the NAO, partnerships are necessary to address "complex issues such as child obesity or community safety, and these clearly work better where local organisations are coterminous."[172] Common service boundaries allow the development of common outcomes to be achieves by all stakeholders. Shared strategies can then be developed to achieve these goals.

In addition, the Local Government Information Unit reported that "coterminosity facilitates greater sharing of data",[173] which allows for a better understanding of population needs. Information sharing also helps the "integrated commissioning and service provision and, therefore, better outcomes for people". [174] A report by the Welsh Commission on Public Service Governance and Delivery, has also emphasised the importance of reducing spatial complexity by increasing the coterminosity of service boundaries.[175] It recommended that local public services should be redesigned "enhance coherence and coterminosity between local authorities and the boundaries and remits of other major service-providers." [176]

165 Ministry of Justice, *Transforming Rehabilitation: A Strategy for Reform* (The Stationery Office, 2013).
166 Ibid, 31.
167 Ibid.
168 Exworthy and Peckham, 'The Contribution of Coterminosity to Joint Purchasing in Health and Social Care'.
169 Ibid, 234.
170 National Audit Office, *Delivering Efficiently: Strengthening the Links in Public Service Delivery Chains*, 2006, 36.
171 Ibid.
172 Ibid.
173 Local Government Information Unit, *All's Well That Ends Well? Local Government Leading on Health Improvement*, 2012, 5.
174 Ibid.
175 Williams et al., *Commission on Public Service Governance and Delivery*, 90.
176 Ibid.

3.2.2 Towards coterminous areas

Achieving coterminosity involves a trade-off between managing to achieve the appropriate size for a geographical area, so that commissioning bodies benefit from economies of scale, and the desire for local solutions.[177]

Nonetheless, commissioners should consider a new model of what these devolved commissioning bodies might look like by overlapping the following boundaries to the greatest extent:

- Health outcomes and their wider determinants;
- Local Entreprise Partnerships (LEPs);
- Sustainability and Transformation Partnerships;
- Local authorities.

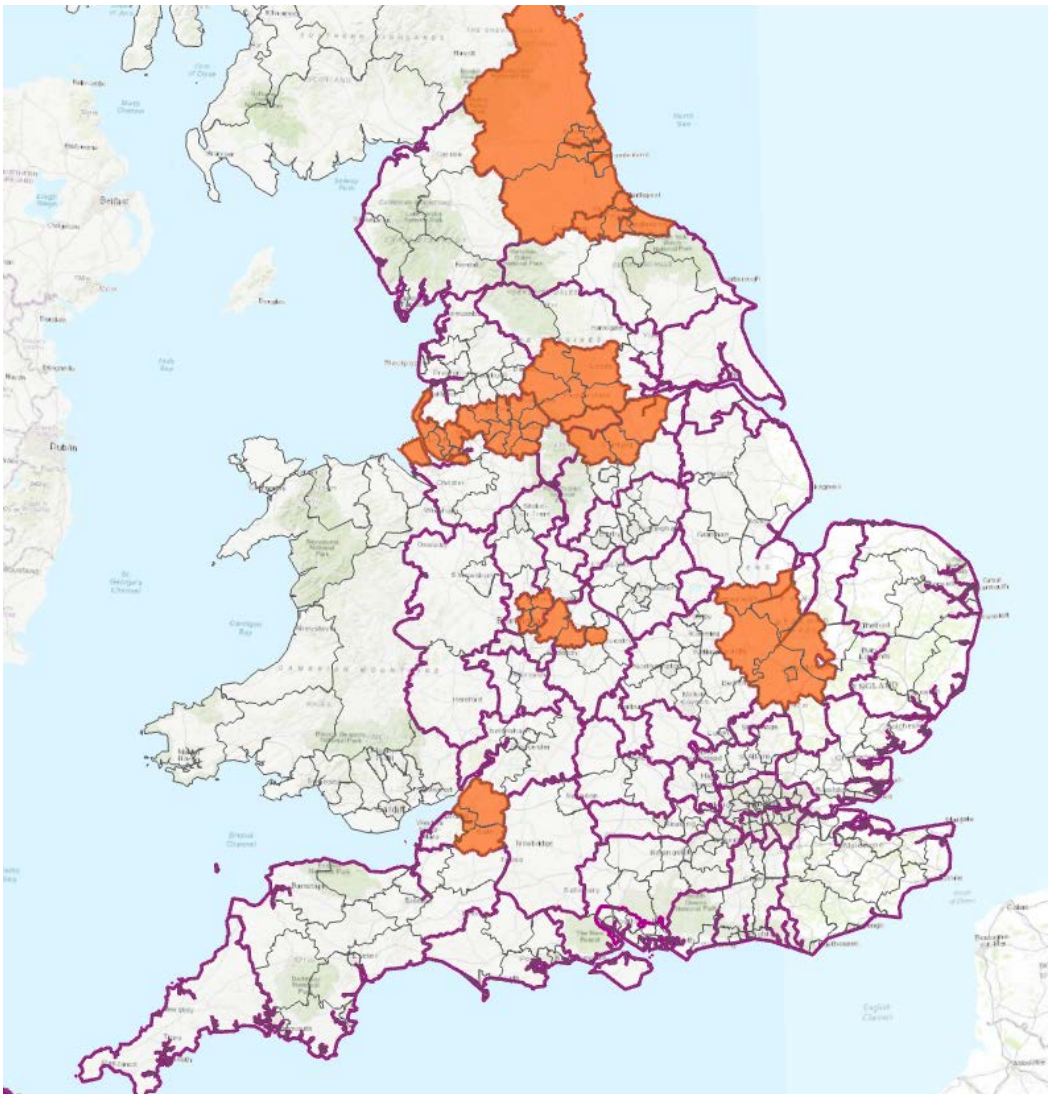
According to Public Health England, the key drivers for poor health can be in large part attributed to "the 'conditions in which people are born, grow, live, work, and age.'"[178] Considering the health needs of local areas as well as the wider determinants of health is crucial to the design of integrated services. Designing commissioning areas where the population has homogenous needs could facilitate the outcomes-based commissioning, compared to the current model of public-services commissioning. In practice, areas with higher levels of employment have lower reoffending rates, lower violent crime rates, higher life expectancy at birth and lower mortality rates from preventable causes.[179] This means that they are coterminous in terms of outcomes, which would allow for the design of singular integrated service based on the needs of the local populations.

As highlighted by Public Health England, the two most important determinants of health outcomes are income and work.[180] Therefore LEPs should be considered when designing coterminous commissioning bodies as they are designed to "operate across functional economic areas that reflect labour markets and offer sufficient economies of scale."[181] This is reflected in Figure 20 which shows that employment rates are relatively homogenous within LEP boundaries.

177 EY, *Independent Analysis of Governance Scenarios and Public Service Reform in County Areas*, 2016.
178 Public Health England, 'Chapter 6: Social Determinants of Health', in *Health Profile for England*, 2017.
179 Reform analysis using Public Health England, 'Public Health Outcomes Framework – Wider Determinants of Health', n.d., accessed 7 September 2017.
180 Public Health England, 'Chapter 6: Social Determinants of Health'.
181 National Audit Office, *Local Enterprise Partnerships*, 2016, 12.

Figure 20: Local authorities, combined authorities and Local Enterprise Partnerships

Grey lines: Local authorities
Purple lines: LEPs
Orange areas: Combined authorities (devolution deals)



3.2.2.1 Coterminous commissioning areas

Government and local authorities should work together and agree on the appropriate number of local commissioning areas. Figure 21 offers a suggestion of how these areas may look. This shows that most areas share coterminous external LEP, STP and local authority boundaries, as shown by the light purple areas.[182]

In other areas, the process would be more complex, where, for example, LEP areas overlap, as shown by the dark purple regions. This would lead to a negotiation process with varying degrees of intricacies in determining boundaries between neighbouring areas. The New Anglia LEP, for example, partially overlaps with the Greater Cambridge and Greater Peterborough LEP; it also includes two STPs which are not coterminous with the New Anglia LEP boundary. In this situation, the LEP boundaries could shift to include the area of overlap between Greater Cambridge and Peterborough into the New Anglia LEP, thereby making the STP boundaries coterminous with the LEP. In addition, the area could benefit from the merging of the two STP to create a single health economy.

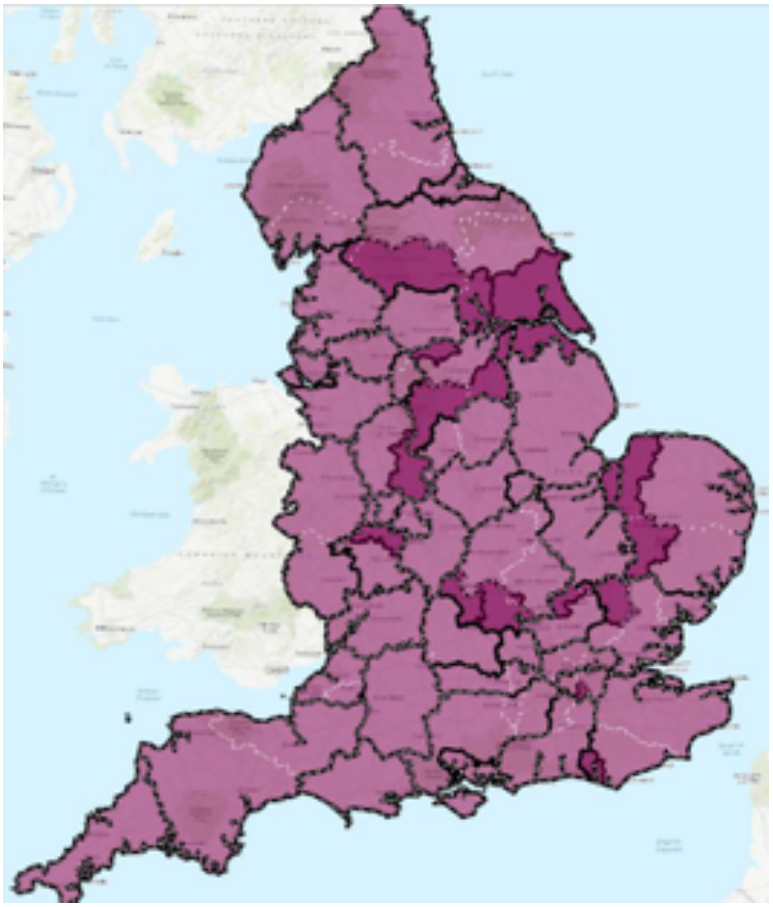
182 As Figure 20 shows, LEP boundaries are not always coterminous with those of local authorities. In *Reform*'s proposed model LEP or local authority boundaries might have to shift to ensure as much coterminosity as possible.

Other areas are even more complex, where two LEPs overlap and both LEPs have coterminous boundaries with STPs. In these instances, both LEPs would have claim to the STP area, and therefore should negotiate between themselves and central government as to where the boundaries should be drawn. An example of this is between the Oxfordshire and Buckinghamshire Thames Valley LEPs.

In total, with STPs (as shown by white dashes on Figure 21) extending to fill LEP areas, *Reform*'s suggested model would result in approximately 38 devolved commissioning areas. This is, however, a suggested outline, from which local areas can negotiate.

Figure 21: Local Enterprise Partnerships and Sustainability and Transformation Partnerships

White dashed lines: STPs
Light purple area and black border: LEPs
Dark purple area and black border: overlapping LEPs



Other factors should be considered in these negotiations. Local identity is one. IPPR's 2012 *The Future of England Survey* demonstrated that 80 per cent of survey respondents felt a strong connection to their local community, more so than to England or the UK.[183] In previous devolution deals, local identity has played a central role in shaping the discussion. In the 2016 West Midlands Devolution Deal, there was considerable debate as to whether the creation of a combined authority would dilute the regional identity of the different areas, including Coventry, Solihull and Birmingham among others.[184] Throughout the negotiations, the parties agreed that the devolution deal would transfer powers from Westminster, rather

183 IPPR North, *The Future of England: The Local Dimension*, 2014, 2.
184 Coventry Observer, 'Coventry and Warwickshire Towns Will "retain Identities" under West Midlands Combined Authority, Says Business Leader', 16 November 2016; BBC News, 'West Midlands Combined Authority: Will Identities Survive Super Council?', 10 October 2016.

than reduce the status of local authorities.[185] Policymakers should continue to consider local identity when agreeing commissioning regions.

In the long-run needs and outcomes may evolve, changing the shape of these 'population boundaries'. This might eventually create tensions with existing commissioning structures. However, structures can evolve and adapt to the new geographies of population outcomes – as local authorities have done in the past, notably in 2009.[186]

Recommendation 5: Government and local areas should ensure the coterminosity of services boundaries when entering devolution negotiations. They should take into consideration population health outcomes, their wider determinants, LEP boundaries, STP boundaries and council boundaries. Taking these elements into account would approximately result in 38 devolved commissioning areas.

185 Birmingham Post, 'Coventry Set to Join Birmingham and Black Country in New Regional Authority', News Release, 19 May 2015.
186 Office for National Statistics, 'Local Government Restructuring', accessed 4 October 2017.

4
Skin in the game: governance models

Devolved commissioning areas will require strong governance to commission services most effectively. These bodies should integrate commissioning teams and be headed by strong, accountable leaders. This is the only way to manage public-service markets effectively. The history of public-services commissioning has been one of new commissioning bodies being created to take on these functions. This need not be the case: current local government structures offer ready-made governance models, which can drive value for money in public-services commissioning.

4.1 Single commissioning bodies

Integrated public services, through which citizens can receive interventions for multiple issues or ailments, can offer better interventions – in many cases for less money. This is well-recognised by government, which, in 2014, said it was "encouraging and even mandating more integrated working and more collaboration between services."[187] Yet, as *Faulty by Design* argued, this has not been achieved. Gaps between services in some areas, overlapping services in others and a failure to invest in prevention methods have resulted from a complex and fragmented commissioning framework, which does not have the incentives to design contracts to deliver integrated services.[188]

A new offer is needed. Single commissioning bodies can align incentives for integration, with teams dedicated to achieving outcomes and not following siloed approaches. Control of the commissioning of the services set out in Chapter 2 should move to combined or unitary authorities. This means disbanding NHS England, CCGs and PCCs.

4.1.1 Lessons from integrated commissioning

This is not to say that commissioners have not worked together to deliver high-quality, integrated public services. Examples of these practices exist, though policymakers have failed to learn how to scale them (see Figure 22).

Figure 22: Integrated services

Commissioners	Services	Outcomes
Central Manchester CCG and Manchester City Council.[189]	Integrated care model to keep vulnerable members of the community out of hospital through extended community and end-of-life care.	People dying in hospital reduced from 55 per cent to 5 per cent across three residential care homes; the area has the same emergency admissions as 2008, after having seen year-on-year growth.
Wigan Borough CCG and Wigan Council.[190]	Integrate 65 GPs into 16 Integrated Neighbourhood Teams and care homes to reduce hospital admissions.	Between April 2013 and January 2014, medium and high-risk patients non-elective admissions reduced by 48 per cent, A&E admissions reduced by 43 per cent and outpatients attendances fell by 17 per cent.

187 Cabinet Office, 'Open Public Services 2014', 14 March 2014.
188 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning*, 17–29.
189 Lauren Roberts and Genevieve Cameron, *Evaluation of the Integrated Care Communities 2 Programme (Incorporating Learning from the Integration Discovery Community),* 2014, 7–12.
190 Ibid, 48–52.

Commissioners	Services	Outcomes
Barnet Council.[191]	Established a task force, comprising housing officers, JCP employees and Housing Benefits officers, provided services to help stop people falling into poverty following introduction of Benefits Cap.	35 per cent of service users helped into work between January and October 2014; return on investment of 1:3 from benefit savings.
Cornwall unitary authority.[192]	Council and JCPs work with 60 partners to provide 'Inclusion Hub' services to help young people into work. Financial rewards are shared between organisations involved.	10,000 people have been helped into work since 2006.
Staffordshire County Council, Stoke-on-Trent City Council and LEP.[193]	£44 million road to Jaguar Land Rover's factory was built.	Expected 1,400 extra jobs.

These are not exhaustive, but offer an insight into the ingredients for successful integration within and across policy areas. These fall into the following categories:

- **Simple (integrated) governance structures.** Commissioning bodies combine to design integrated services to meet clear local needs. STPs show the difficulty of multiple commissioning bodies delivering single approaches.[194]
- **Align funding incentives.** A clear return on investment for all the partners involved is key to incentivise resource-limited commissioners to invest in new approaches to delivering services. This may be through pooled budgets, or a clear understanding of where the integration of services will reduce resource spending in the future.
- **Information sharing.** Risk-stratification of citizens (with respect to health or offending, for example) is a key lever to target commissioning and achieve returns on investment.
- **Clear aims.** Clear outcomes should be set by commissioners, with providers designing the services to achieve them. Aims should be shared across commissioners and match local needs.
- **Strong leadership.** Accountability and ownership of the commissioning of projects is crucial to push services in the same direction. Leaders should be confident to set the types of outcomes aims described in Chapter 2.
- **Engage partners.** Providers of services need clarity over aims of new approaches and rewards for changing working practices. This should be done from the earliest possible stage to bring them along on the journey, and take on feedback on what is possible. This includes current providers from independent and voluntary sectors, as well as potential market entrants.

To scale these successful approaches, the above themes should be applied to a new commissioning framework.

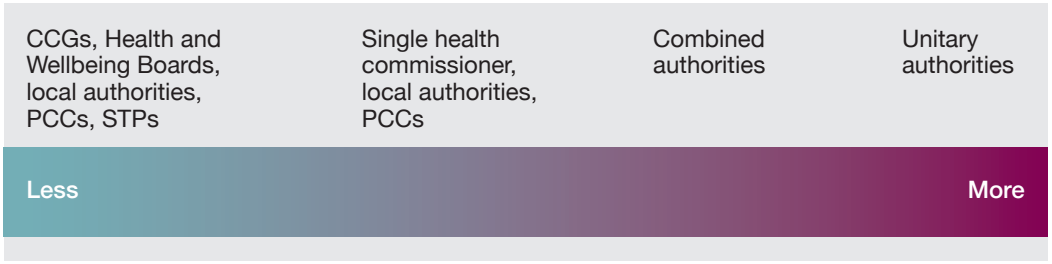
191 Localis, *Local Authority Transformational Models: Whole-Council Approaches to Transformation,* 2016.
192 Local Government Association and Learning and Work Institute, *Work Local. Our Vision for an Integrated and Devolved Employment and Skills Service*, 2017.
193 Localis, *Local Authority Transformational Models: Whole-Council Approaches to Transformation.*
194 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*

4.1.2 Integrated commissioning bodies

The starting point for commissioning integrated services is to build single organisations to design and be accountable for achieving outcomes. In 2012, the Health Select Committee argued for single health-and-social-care commissioning bodies to oversee the integration of health and social care.[195] These would incentivise commissioners to, themselves, incentivise providers to deliver care for people requiring social care outside of hospital.[196] Recently PwC has argued for the creation of Regional Care Groups, replacing STPs and controlling financial resources within the STP area, including the commissioning of primary care and specialist services as well as mechanisms to intervene in wider local commissioning.[197]

New acronymed bodies do not need to be created to fill these functions, however. Government has models which can integrate commissioning functions at a local level. Combined authorities and unitary authorities (see Figure 23) offer integrated bodies to commission services.

Figure 23: Levels of integration of commissioning bodies

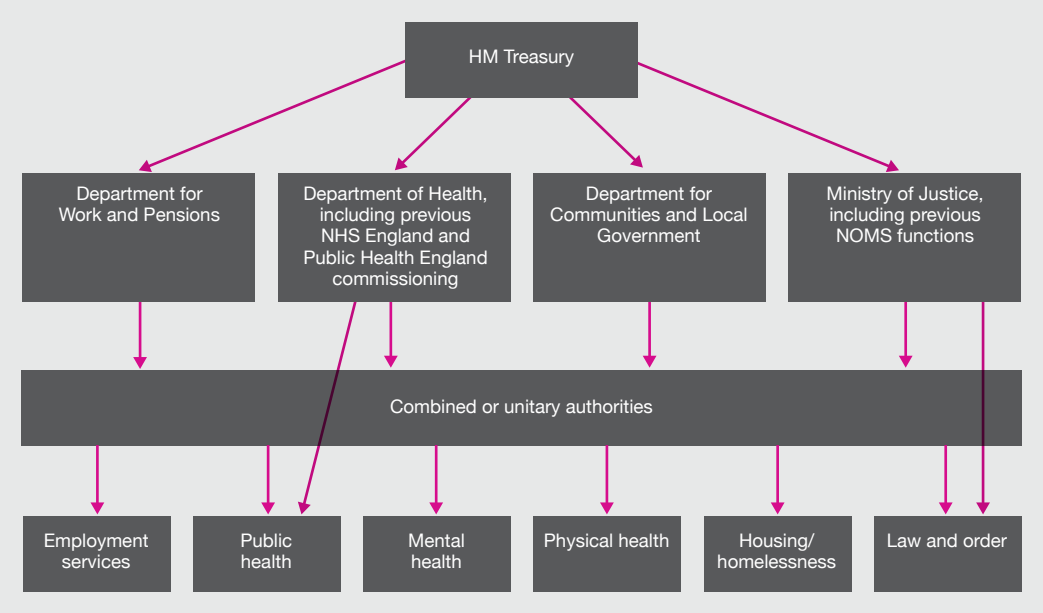


These bodies are well-placed to cover regions set out in Chapter 3 and commission the complex human services identified in Chapter 2. The NAO has pointed to combined authorities as achieving a "common sense of purpose" amongst constituent councils by creating an integrated governance structure to work towards defined aims.[198] Cornwall based its case for moving to a single unitary authority on overcoming duplications arising from multiple commissioners and service providers, and making interactions between local government and other commissioners, such as health, more efficient.[199] It further argued: "There are significant savings and efficiencies to be made by bringing together public services in a more coordinated and strategically focused way."[200] Places like Hampshire, which include metropolitan and non-metropolitan areas, have argued that a single unitary authority offers better integration of services than the current multi-tiered local-authority structure.[201]

Single commissioning bodies would go further than current practice to incorporate the duties of current commissioning bodies such as local authorities, CCGs, NHS England and Health and Wellbeing Boards (see Figure 24). Central government should retain control of some functions for which standardisation is required, such as for immunisation programmes, or where a very small number of people use the services (see Chapter 5).

195 House of Commons Health Committee, *Social Care, Fourteenth Report of Session 2010– 12. Volume I*, 2012.
196 Ibid.
197 PricewaterhouseCoopers, *Redrawing the Health and Social Care Architecture. Exploring the Role of National Bodies in Enabling and Supporting the Delivery of Local Health and Care Services*, 2016, 5.
198 National Audit Office, *Progress in Setting up Combined Authorities*, 23.
199 Cornwall County Council, *One Cornwall One Council. Part One*, 2007, 20.
200 Ibid, 24.
201 Ipsos MORI and Hampshire County Council, *Serving Hampshire. Understanding the Public's Views about Possible Local Government Reorganisation in Hampshire. Final Report*.

Figure 24: Suggested money flow from selected commissioning bodies



Note: Ministry of Justice includes prison place, which are not referred to in this analysis, but the commissioning of some of which will likely remain central

This framework would offer a level of coherence that today's does not. In theory, this should help avoid the current lack of or ambiguity of responsibility for designing services to meet the overlapping needs of people, which will eventually be picked up by one service.[202] For example, a person with a drug addiction is more likely to find themselves in A&E or prison,[203] but councils, PCCs and the NHS all fund rehabilitation services. Passing responsibility for these people to one body aligns incentives and allows commissioners to design contracts which can incentivise the most effective interventions. Charlie Taylor points to the importance of locally linking education and training to the rehabilitation of young offenders, to help them rebuild their lives.[204] As the examples in Figure 22 show this type of approach promises to deliver returns on investment across different services.

Examples of this in practice point to its benefits. Scandinavian models offer guidance for health and social care. In Finland, local authorities oversee the provision of primary, secondary and social care in regions smaller than suggested in Chapter 3 – of up to 600,000.[205] In Sweden, councils (of which there are 21) have responsibility for all health and social-care commissioning, which has allowed them to design integrated care across the country, including 'multidisciplinary home care teams', 'rehabilitation teams' – with councils such as Jonkoping offering world-leading integrated approaches for elderly patients with chronic conditions.[206] Councils also partner with municipalities to offer vocational rehabilitation to help return people to employment – a partnership motivated by the councils funding 70 per cent of healthcare expenditure through taxation raised in local economies.[207] In the Netherlands, municipalities control employment-services, adult-education and youth and social-care budgets, used to integrate services in one-stop shops.[208]

202 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning*, 27.
203 Heys and Lockyer, *Local Commissioning, Local Solutions*.
204 Taylor, *Review of the Youth Justice System in England and Wales*, 4.
205 Stubbs, *Devolved Healthcare in Finland*, 2.
206 Ewbank, Hitchcock, and Sasse, *Who Cares? The Future of General Practice*.
207 Bengt Ahgren and Runo Axelsson, 'A Decade of Integration and Collaboration: The Development of Integrated Health Care in Sweden 2000–2010', *International Journal of Integrated Care* 11, no. Special 10th Anniversary Edition (9 March 2011): 2000–2010.
208 Local Government Association and Learning and Work Institute, *Work Local. Our Vision for an Integrated and Devolved Employment and Skills Service.*

Moving to single commissioning bodies would require legislative change, which can be delivered in stages to work with the staggered process of devolving public-services commissioning (see Box).

Single, local commissioning authorities: legislative change needed

Stage 1: basic devolution

National Health Service Act 2006. Section 75 should provide for the pooling of funding and commissioning of specific services currently omitted from joint commissioning, including ambulatory services, surgery, radiotherapy and others.

Crime and Disorder Act 1998. Requires local authorities to establish a Youth Offender Team, which can hamper the design of local approaches. This section should be repealed.

Stage 2 and 3: enhanced and full public-services devolution

Health and Social Care Act 2012. Establishes NHS England, Clinical Commissioning Groups and Health and Wellbeing Boards as NHS commissioning organisations. Legislates for Public Health England. These parts, along with elements related to national tariffs that bind local commissioning decisions, should be repealed.

Cities and Local Government Devolution Act 2016. Provides combined authorities with the power over housing, transport and policing powers. Should be amended to widen these powers to unitary authorities, and provide combined authorities and unitary authorities with power over health, employment and offender-management commissioning, as set out in Chapter 2.

Recommendation 6: A combined authority or a unitary authority should cover a commissioning area and take on all devolved commissioning functions for healthcare, employment services, skills and apprenticeships, and offender management.

4.1.2.1 Paying for new structures

Single commissioning bodies would also deliver administrative savings and free up money currently spent on numerous arm's-length commissioning bodies.

Rationalising local government could deliver administrative savings. In 2016, the Treasury argued that the creation of combined authorities and mayors would be fiscally neutral due to making better use of the local government workforce.[209] In the same year, EY found that switching to 27 countywide unitary authorities across England could save billions through economies of scale and reducing staff at all levels (see Figure 26). Savings have materialised in practice. In Cornwall, the initial cost of six district councils moving to a unitary council was £39.5 million but the reorganisation is now delivering ongoing efficiency savings of £15.5 million a year.[210]

209 Public Accounts Committee, *Oral Evidence: Cities and Local Growth*, HC 913, 2016, 36.
210 Michael Heseltine, *No Stone Unturned in the Pursuit of Growth*.

Figure 25: Projected savings from non-metropolitan unitary authorities across England

Scenario	Savings (over five years)
27 unitary authorities: one per area	£2.37 million to £2.86 billion
54 unitary authorities: two per area	£1.17 billion to £1.7 billion
81 unitary authorities: three per area	£526 million to a net cost of £33 million
Three unitary authorities and a combined authority per area	Net cost of £36 million to £366 million

Source: EY, *Independent Analysis of Governance Scenarios and Public Service Reform in County Areas*, 2016.

Reducing other commissioning bodies will free up money, which in turn could be spent more efficiently. Current commissioning bodies in health and offender management cost £4.6 billion to run each year. This money can be channelled into new bodies, in the form of employees and capital spend for new infrastructure (see Figure 26).

Figure 26: Administration spend within commissioning bodies, 2015-16

Commissioning body	Administrative spend (gross)	Employee remuneration (gross)
Clinical Commissioning Groups	£1.3 billion	£1.2 billion
NHS England	£398.5 million	£806.6 million
National Offender Management Service (now part of Ministry of Justice) and Area Services	£139.2 million	£81.9 million
Police and Crime Commissioners	£70.38 million	
Total	**£4.63 billion**	

Sources: NHS England, *2015/16 Annual Report: Health and High-Quality Care for all, Now and for Future Generations*, 2016; Ministry of Justice, *National Offender Management Service Workforce Statistics: June 2015*, 2015; National Offender Management Service, *Annual Report and Accounts 2015 – 2016*, 2016.

Note: NOMS and Area Services employee benefits is likely to be higher. Figures are calculated from applying median remuneration to these employees, but senior managers earn six times this.

Police and Crime Commissioner spend based on a sample of nine Offices of Police and Crime Commissioners across the country.

4.2 Commissioning leaders

Strong leaders should sit atop these single commissioning bodies to coordinate commissioning decisions and provide accountability for decisions made within local areas.

4.2.1 A pragmatic approach to mayors

Strong commissioning areas will need strong leadership. This starts at the top and requires individual leaders to provide a single point of authority to push for change, develop a vision for public-service reform, and be held accountable for the success of public services commissioned within their areas.

The Government requires devolution areas to have directly elected mayors to qualify for the devolution of significant powers. In 2017, six of these mayors were elected, to join London's mayor, which has been in place since 2000.

In theory, there is a strong case for directly elected mayors holding responsibility for commissioning public services. Mayors receive democratic mandates to deliver a programme for local government. In Greater Manchester, Andy Burnham received 359,352 votes in 2017.[211] In practice, mayors have been seen to offer better clarity of responsibility for decision-making than council officials. For example, in the two years following the election of a metro mayor in Bristol, the proportion of residents who felt the responsibility of decision-making was clear more than doubled.[212] As Chapter 1 outlines, mayors have used their positions to drive change.

Despite a strong case for mayors, some areas have fought against their imposition. Interviewees for this paper in local authorities expressed concern that mayors did not suit all areas. In Cornwall, the mayor model was rejected based on little political appetite, four-year terms being too long for an unpopular mayor (without recourse to deselection) and concerns that a mayor might hold a specific type of attitude.[213] This has had serious implications: Hampshire's devolution deal fell apart after councils could not agree to a mayor, which led to "pandemonium", wasted time and a "bad taste" according to one interviewee close to the matter. Deals in West Yorkshire, the West of England, East Anglia and Lincolnshire have been disrupted and changed because of concerns of at least one council's resistance to a mayor.[214] Since 2001, 37 of 53 local referenda on the introduction of a directly elected mayor have resulted in rejections.[215] These disagreements should not scupper devolution deals.

Cornwall has started to square this circle by electing a council leader atop a cabinet.[216] The region argues that this model offers a more "streamlined and dynamic" decision-making model than previous committee models. With four-year terms instead of the previous one year, a council leader can offer stability and vision within the region.[217] There are no theoretical barriers to council leaders getting as much exposure, or being able to wield significant soft power to bring public services and the business community together.[218] With integrated governance, the argument for strong mayors as integrators of executive functions is also diluted.[219]

211 BBC News, 'Elections 2017 Results: Tories Win Four New Mayors', *BBC News*, 5 May 2017.
212 Robin Hambleton and David Sweeting, *The Impacts of Mayoral Governance in Bristol* (University of Bristol, University of the West of England and Economic and Social Research Council, 2015), 31.
213 Governance Review External Group, *Primed for Success. Cornwall Council Strategic Governance Review*, 2016, 21.
214 British Academy, *Governing England: Devolution and Mayors in England*, 5; Stefan Pidluznyj, 'Scrapped: Lincolnshire's £450 Devolution Deal No More', The Lincolnite, 11 November 2016.
215 British Academy, *Governing England: Devolution and Mayors in England*, 5.
216 Governance Review External Group, *Primed for Success. Cornwall Council Strategic Governance Review*.
217 Ibid, 20.
218 Sam Sims, *Making the Most of Mayors* (Institute for Government, 2011), 16.
219 Ibid, 15.

Government should therefore be flexible and allow local areas to build the case for different leadership models. Local politics should not be a reason for rejecting mayors, however.

Recommendation 7: Local commissioning boards should be headed by a single leader accountable for these decisions. Mayors should not be mandated by central government, however, and local areas should be able to shape their own leadership structure if one elected official holds a time-limited position accountable for public services across the local commissioning region.

4.2.1.1 Leaders focusing on commissioning public services

Debates about the role of mayors have distracted from a key theme of devolution: the ability for strong leaders to reform public services through commissioning. No mayoral area has achieved this yet. Two decades of London mayoralty have not resulted in NHS commissioning power filtering to the capital.[220]

Elsewhere, mayors have led public-service reform. In Japan, Yokohama City's mayor, Fumiko Hayashi, has worked to reduce services which overlap with a surrounding area.[221] Another example is Michael Bloomberg's 12-year tenure in New York (see Box). In Auckland, New Zealand, for example, mayors have been praised for developing a vision to make the city "the world's most liveable city" to improve wellbeing, rather than compete with financial centres on more narrow measures of growth.[222]

Bloomberg's New York

Michael Bloomberg held office as New York's mayor for 12 years. He took up his position months after the September 11 attacks on the city, with a budget deficit of up to $5 billion, and led the city through Hurricane Sandy the following year.

Bloomberg introduced health policies such as cutting smoking, publishing calorie counts, creating outdoors spaces, cycle route and pushing to reduce greenhouse gases. He oversaw the creation of the 311 telephone number, which allows residents to report a host of public order concerns, such as graffiti, odd smells and traffic issues. Homelessness rose under his leadership, however. Yet, Bloomberg delivered a $2.4 billion budget surplus when departing office.

Sources: Editorial, '12 Years of Mayor Bloomberg', *The New York Times*, 28 December 2013; The Economist, 'Bye-Bye, Bloomberg', 11 February 2013; Philip Sherwell, 'Michael Bloomberg 'Spent $650 Million of Own Money' as New York Mayor', *The New York Times*, 30 December 2013.

UK mayors should follow these predecessors to push for control of public-service commissioning. Interviewees argued that with central government focusing much attention on Brexit negotiations, mayors can answer the question: "who speaks for England?" raised following the result of the Scottish referendum in 2014. That is, making the case for the full control of public-service commissioning for their areas to deliver public-service reform.

220 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*
221 Japan Local Government Centre, 'City Devolution Models, Japan's "Designated Cities"', Newsletter, n.d., accessed 17 August 2017.
222 Louis McGough, 'What Can the UK Learn from Auckland on Metro Mayors and City-Regions?', *Centre for Cities*, 20 November 2014.

4.2.2 Strong decision-making: a cabinet of public-service leaders

Devolution presents an opportunity to break commissioning silos. It will not happen without careful planning, however. Leaders should drive this as single accountable figureheads within local commissioning regions.

The key to achieving this is designing the decision-making architecture under leaders in the way that incentivises commissioners to act as one to design and procure services to meet residents' needs most effectively. A range of options are currently available (see Figure 27), which operate at local authority and combined authority levels. While no one option will fit every region, there are traits local commissioning bodies should look to maximise.

Figure 27: Governance models

Local authority models	Devolution area models
Leader and cabinet. This is the most common governance system for councils. Either individual members of a cabinet have decision-making powers, or the whole cabinet must agree. The cabinet is headed by a leader elected by the council for a term determined by the council, or four years.	**London.** The Greater London Authority (GLA) comprises the mayor and the assembly. The 32 boroughs and City of London commission key services, such as children's services and adult social services. The boroughs have either a leader and cabinet or executive mode, or mayor and cabinet or executive model. The GLA assembly consists of 25 elected members, scrutinising the mayor's executive role on a range of issues, including air quality, transport and waste and economic development. Executive bodies – Transport for London (TfL), the Mayor's Office for Policing and Crime (MOPC), and the London Fire and Emergency Planning Authority (LFEPA) – carry out much of the work of the GLA.
Mayoral system. A directly elected mayor holds decision-making powers. The mayor appoints a cabinet comprising councillors, who may have decision-making powers.	**Greater Manchester.** The mayor holds decision-making power and is supported by deputies appointed by the mayor. The combined authority comprises 10 members, elected from Greater Manchester councils. The chair and vice chair of combined authority is elected from amongst members. The mayor must consult this cabinet on decisions, and the cabinet may reject plans if two-thirds of members agree to do so. Commissions comprising local authority members and external stakeholders to develop policy in individual policy areas, with decisions approved by the combined authority.
Committee system. Decisions are made in committees comprising a mix of councillors from all political parties.	**Cornwall.** Unitary authority with leader and cabinet.

Sources: Local Government Association, *Rethinking Governance. Practical Steps for Councils Considering Changes to Their Governance and Arrangements*, 2014; Greater Manchester, *Taking Charge of our Health and Social Care*, 2015; London Councils, *The Essential Guide to London Local Government*, 2017.

These models are similar to international models.[223] In Auckland, the unitary authority comprises 20 councillors that work to set regional strategies, such as the 30-year Auckland Plan, set budgets and oversee the commissioning of services such as transport and property executed via boards independent of Auckland Council but accountable to it.[224] Councillors are elected from the 13 wards comprising the unitary authority, with the aim of combining local representation with regional governance.[225] However, concerns have been raised that the board structure is too complex for residents and businesses to engage with and that too much power has been put in the hands of unelected officials heading these boards.[226] Metro, in Portland, USA, employs a smaller model of governance, with six councillors and a president setting strategies for a region of a similar size to Auckland Council.[227] Metro has powers over transport, regional growth and regional attractions, among other areas.[228] It is "widely recognised as a highly successful model of regional governance in the USA" according to Hambleton.[229]

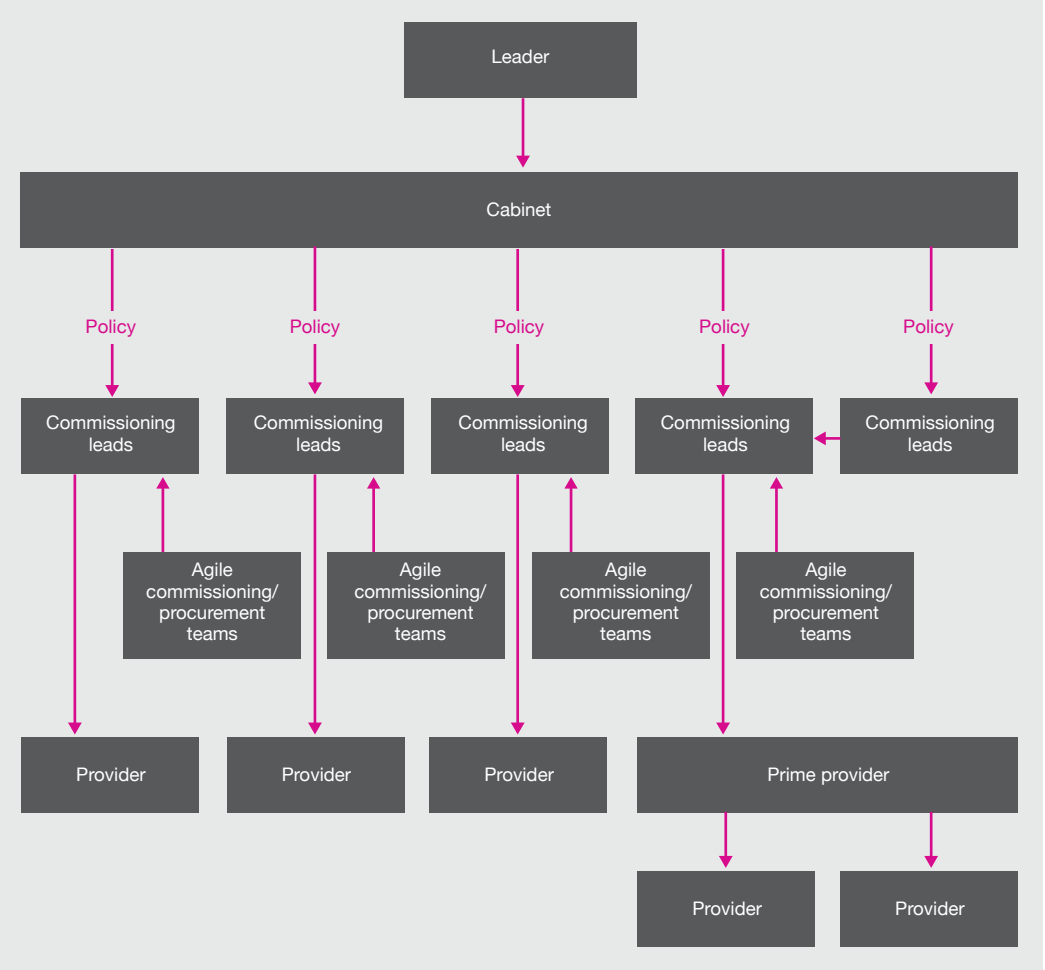
International examples and the early experience of the UK suggest that small cabinet governance offers an efficient approach with clarity of vision, but different forms of governance will suit different areas.

A more radical approach to breaking silos would be to redefine policy briefs and commissioning boards based on outcomes. In 2007, the Scottish Government partially abolished its departmental structure and reduced the number of director-level senior civil servant roles by 25 per cent.[230] According to McKinsey, this led to a reduction in cost of administration and improvement in performance.[231] In 2012, New Zealand implemented its Better Public Services (BPS) reform agenda, which focuses on 10 priority outcomes, which civil servants and government departments are expected to work together to achieve.[232] The Government is on course to achieving many of its self-imposed aims.[233] This is a central model, but could be applied locally.

Local commissioning structures based on these approaches would offer a streamlined, integrated approach to local public-service commissioning (see Figure 28). It would also focus commissioning on meeting issues at hand, rather than automatically following previous approaches. Commissioning leads would be filled by Accountable Officer and Chief Financial Officer roles to hold statutory responsibility for the spending of public money, with the cabinet and leader being accountable to the local electorate. Agile procurement teams can be formed, bringing together procurement officials from different policy areas depending on the service being commissioned, which can then be disbanded once the tendering process has been completed. Small teams can provide contract management throughout the life of programmes.

223 Local Government Association, *English Devolution: Local Solutions for a Successful Nation*, 2015.
224 Auckland Council ,'Auckland Council Explained', (Webpage), accessed 12 July 2017.
225 Robin Hambleton, *English Devolution: Learning Lessons from International Models of Sub-National Governance* (Local Government Association, 2016), 23.
226 Ibid, 23–24.
227 Ibid, 35.
228 Ibid, 33.
229 Ibid.
230 Sir John Elvidge, *Northern Exposure. Lessons from the First Twelve Years of Devolved Government in Scotland* (Institute for Government, 2011).
231 David Chinn et al., *World-Class Government Transforming the UK Public Sector in an Era of Austerity: Five Lessons from around the World* (McKinsey & Company, 2015), 17.
232 State Services Commission, 'Better Public Services', Webpage, 31 October 2016.
233 For progress, see: State Services Commission, 'Better Public Services: Results for New Zealanders', 7 August 2013.

Figure 28: Suggested governance structure for local commissioning bodies



Recommendation 8: Local commissioning bodies should form around the outcomes set by the cabinet and leader. Agile procurement teams should tender contracts, and disband after.

4.3 Skills and culture

A new set of skills and different cultures are required amongst local commissioners to deliver these approaches. Responsibility for over £100 billion of public spend makes this acute.

4.3.1 Skills

The ability of commissioners to design and procure complex services, or commission for outcomes has been called into question many times.[234] This has been the case for central and local government commissioners, and CCGs.[235] This point is often overlooked when considering devolution: the status quo is as variable as local authority or CCG commissioning. The Transforming Rehabilitation contracts show that central government has failed to learn from inside Whitehall and contracts are poorly designed as a result.

234 Harwich, Hitchcock, and Fischer, Faulty by Design. *The State of Public-Service Commissioning*, 11–13.
235 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning*; Hitchcock, Pickles, and Riggs, *The Work and Health Programme: Levelling the Playing Field*; National Audit Office, *Personalised Commissioning in Adult Social Care*, 2016; Dan Crowe, Tom Gash, and Henry Kippin, *Beyond Big Contracts* (Institute for Government, 2014); Hannah Fearn, 'Council Staff Lack Skills to Commission Public Services, Survey Finds', *The Guardian*, 14 January 2013.

Local commissioners can do more, however, to improve commissioning skills and therefore value for money. Commissioners have used consultants to provide advice and help. In 2015-16, NHS England, including CCGs, spent £113 million on consultancy services.[236] This compares to £142.4 million on education and training.[237]

Recent governments have responded by committing to upskill the commissioning workforce, including via the Commissioning Academy established in 2013.[238] The LGA has tailored approaches to local government, such as through the Commissioning Academy for Elected Members.[239] Anecdotal evidence points to positive outcomes from these programmes, although no comprehensive evaluation has been made. [240] For example, Cheshire West and Chester Council partnered with the Commissioning Academy to implement its whole-place community budget, addressing serious local issues, such as domestic abuse, by targeting early causes and thereby preventing harm from occurring.[241] Integrating commissioning teams – CCGs, local authorities, health trusts, police and housing – delivered services which reduced domestic-abuse arrests by 35 per cent, reduced "inappropriate" referrals to children's social care by 23 per cent and resulted in £570,000 cashable savings to the council.[242] Other councils, such as Sutton and Gloucestershire, have also reported positive outcomes when engaging with the Commissioning Academy.[243]

Commissioners could move from central government to local commissioning bodies. Interviewees argued that experienced staff should follow commissioning powers to devolved regions to bolster skills. Canada transferred federal staff to the provinces when decentralising employment services.[244] This should only happen on merit, however, and not follow automatically.

This should be built on as commissioning is devolved. The technical skills, and market understanding, must be there – and much has been written on how these can be bolstered.[245] These must be a priority for commissioners, as they are now. The pooling of education and training spend between healthcare, local authorities and other commissioning functions (as well as a shift from consultancy spend to upskilling the workforce to target integrated commissioning for outcomes) presents opportunities to spend training money in the most efficient way.

The devolution agenda should be accompanied by new thinking about how outcomes can be achieved through commissioning. This requires a new attitude to risk and ability to innovate. Commissioners could apply ideas such as 'design thinking' from the private sector (see Box).

236 NHS England, *Annual Accounts*, 2016, 154.
237 Ibid.
238 Cabinet Office, Efficiency and Reform Group, and Crown Commercial Service, 'The Commissioning Academy', 3 February 2016.
239 Local Government Association, *Commissioning Academy for Elected Members*, (Webpage), accessed 20 July 2017; Local Government Association and Commissioning Academy, *Highlighting Political Leadership: The LGA Development Offer*, 2016.
240 Public Service Transformation Academy, 'The Better Commissioning of Public Services', (Webpage), 19 March 2015.
241 Cheshire West and Chester Council, Commissioning Academy, and Department for Communities and Local Government, *Commissioning Case Study. Cheshire West and Chester's Whole Place Community Budget – 'Altogether Better, Safer Communities, Integrated Early Support'*, 2016.
242 Ibid.
243 Sutton Council and Commissioning Academy, *Commissioning Case Study: Commissioning for Outcomes and Measuring Social Impact in Sutton*, 2016; Gloucestershire County Council and Commissioning Academy, *Commissioning Case Study: Commissioning for Better Outcomes in Gloucestershire*, 2016.
244 Francesca Froy et al., *Building Flexibility and Accountability Into Local Employment Services: Synthesis of OECD Studies in Belgium, Canada, Denmark and the Netherlands* (OECD, 2011), 22.
245 See, for example: Crowe, Gash, and Kippin, *Beyond Big Contracts*; House of Commons Public Administration Select Committee, *Government Procurement. Sixth Report of the Session 2013-14*, 2013, 2013–14.

Design thinking: commissioning for outcomes

Design thinking is the concept of understanding the experience of service users (particularly emotional ones), and designing services which best meet these needs – developing iterative prototypes and accepting failure as part of the process of achieving success.[246] It flows from the private sector and the approaches of companies such as Apple which look to enhance the experience of consumers, from purchase to the use of devices.[247]

Commissioners would not need to follow all aspects of design thinking due to the purchaser-provider split, but the concept of understanding user experience of services is appropriate. This becomes acute as local commissioners take more responsibility for services. For example, a focus of secondary-care commissioning could move away from meeting waiting times to the satisfaction of being in A&E, as well as the ultimate outcome. Understanding this could also enable commissioners to better assess the service offered during the procurement phase, allowing them clearer insights into whether the service will achieve stated experiential as well as outcome aims.

4.3.2 Culture

Breaking policy silos also requires a shift in culture. Interviews for this paper with officials from local authorities and NHS commissioning bodies revealed a tense atmosphere between the organisations – one of suspicion as to motives and belief that the other was not working to achieve the same aims. One Council CEO also spoke of health and social care being "divided by a common language." Agile team working should help with this, but an inclusive culture which pays respect to different previous approaches to commissioning must be fostered by leaders within new commissioning bodies.

Indeed, Greater Manchester's success has been aided by a long history of local authorities and health commissioners working closely together to achieve outcomes for residents. In Cornwall, those working in the NHS "appreciated the Council's stance in standing 'shoulder to shoulder' with them over the financial challenges they face."[248] Cornwall has also seconded workers between the NHS and the council to understand different perspectives and cultures.

4.4 Contract design and public markets

Commissioners have a crucial role overseeing the healthy functioning of public-service markets. All the services set out in Chapter 2 could be delivered by independent organisations, either from the private, charity or public sector. To get the best value for money from these providers, commissioners should use competitive markets to drive down cost, improve value and pay overwhelmingly for outcomes. This is an idea that has lost support in some quarters, but should be supported by government. While arguments are made on both sides of the debate, evidence points to public-services markets delivering improvements, so long as barriers to competition are removed.

4.4.1 Competition for service provision

Functioning public-service markets have not materialised fully. Some areas, such as employment services, have been outsourced for many years and have stoked competition for contracts, requiring small tweaks to remove lingering market-entry barriers.[249] Competition for the Work Programme and Work and Health Programme have incentivised numerous bidders and led to market exit. Improving supplier engagement, removing

246 Jon Kolko, 'Design Thinking Comes of Age', *Harvard Business Review*, 1 September 2015.
247 Ibid.
248 Governance Review External Group, Primed for Success. Cornwall Council Strategic Governance Review, 17.
249 Hitchcock, Pickles, and Riggs, *The Work and Health Programme: Levelling the Playing Field*.

administrative barriers, such as parent-company guarantees in some cases, and weighting bids more heavily on quality rather than just cost can improve competition even further in local commissioning areas.[250]

There has long been a debate over the right amount of competition for healthcare provision within the NHS. Since the creation of the internal marker in the 1990s competition for contracts has been government policy – with patient choice of provider codified in 2006. Opponents point to systemic flaws, such as costly bureaucratic oversight of the internal market from commissioners, poor information to aid patient choice, profit seeking and even supplier-induced increase in demand.[251] Proponents point to competition driving higher productivity, better choice and higher-quality care as poor providers are driven out the market.[252]

The NHS has the worst of both worlds. Currently, GPs are contracted by NHS England to deliver services to registered lists of patients, via one of three contracts. There is little or no competition to hold these contracts, however. In the year to August 2016, 47 contracts were tendered for 96 GP sites across England.[253] That represents 1.3 per cent of practices.[254] Contracts are designed for this: General Medical Services contacts, which fund 60 per cent of practices, have no end date; and Personal Medical Services contracts, which fund almost 40 per cent of practices, are subject to negotiation, but in practice have no end date or are renegotiated (not re-tendered) periodically.[255] Activity-based funding coupled with bailouts for trusts running deficits do not use market forces to raise productivity.

The NHS has responded by proposing to end the purchaser-provider split in places. Accountable-care systems integrate healthcare providers and commissioners within an STP area.[256] Nine have been announced as of June 2017, covering seven million people.[257] This would end the purchaser-provider split, sidelining commissioners. They are therefore different from USA-style accountable-care organisations, where independent providers are commissioned to deliver care. Despite accountable-care systems being given capitated budgets, providers would be driven by central aims rather than competition.

Despite the continuing debate, this would be a mistake. Choice and competition have been shown to drive efficiency and quality improvements in the NHS. In England, Cooper et al. found that "hospital competition in markets with fixed prices can lead to improvements in clinical quality".[258] Kessler and McClellan conclude that competition between US hospitals can improve quality and control costs.[259] Evidence from the OECD, International Monetary Fund and others suggests that competition can be used "effectively to create a system that's responsive and to incentivise high quality and efficient care."[260] Competition between GP practices has been associated with quality.[261] In Derby, for example, a private provider commissioned to provide primary-care services in 2007 improved access and performance – and possibly increased performance of nearby practices.[262]

250 Ibid.
251 Penelope Dash and David Meredith, 'When and How Provider Competition Can Improve Health Care Delivery', *McKinsey & Company*, November 2010.
252 Michael E. Porter and Elizabeth Teisberg, 'Redefining Competition in Health Care', *Harvard Business Review*, 1 June 2004.
253 Search made in January 2017. European Union, *Tenders Electronic Daily*, 2017.
254 *Reform* calculations. National Audit Office, *Improving Patient Access to General Practice*, 2017.
255 BMA, 'NHS Contracts for Primary Medical Services', 20 September 2016.
256 NHS England, 'NHS Moves to End "fractured" Care System', 15 June 2017.
257 Ibid.
258 Zack Cooper et al., 'Does Hospital Competition Save Lives? Evidence From The English NHS Patient Choice Reforms*', *The Economic Journal* 121, no. 554 (1 August 2011): F228–60.
259 Daniel P. Kessler and Mark B. McClellan, 'Is Hospital Competition Socially Wasteful?', *The Quarterly Journal of Economics* 115, no. 2 (2000): 577–615.
260 Isabelle Joumard, Christophe Andre, and Chantal Nicq, 'Health Care Systems: Efficiency and Institutions' (OECD, 2010); Carlo Cottarelli, 'Macro-Fiscal Implications of Health Care Reform in Advanced and Emerging Economies' (International Monetary Fund, 2010); Dash and Meredith, 'When and How Provider Competition Can Improve Health Care Delivery'.
261 Chris Pike, *An Empirical Analysis of the Effects of GP Competition*, 2010.
262 Dash and Meredith, 'When and How Provider Competition Can Improve Health Care Delivery'.

Other studies have drawn the causal link between higher competition in secondary care (that is, less market concentration) and fewer Acute Myocardial Infraction death rates (used as a proxy for hospital quality).[263] The same links have been drawn between competition and efficiency.[264] Following the 2000s reforms on patient choice, Gaynor et al. find that patients exercised choice rationally – choosing better hospitals over nearer ones.[265]

For value for money to be delivered through competition for market place from a purchaser-provider split, providers need to be allowed to operate as they see fit (without onerous input or output targets), feel the pressure of market exit, have the space to invest in approaches and be rewarded fairly for this investment and delivery of services. This requires contract length and size to be right, outcomes to be paid for and information to be used to design contracts that accurately price value for money.

4.4.1.1 Contract size and length

To incentivise competition commissioners must strike a fine balance between contracts that are too large and therefore only in play for the biggest companies, and those which are too small to deliver economies of scale over multiple services. How contracts achieve this balance will ultimately be down to individual commissioners, depending on the state of the public-service market supply side in their area. But previous approaches offer guidance to local commissioners.

Healthcare contracts are likely to be the highest value, given the total spend on healthcare and the number of services that need to be combined within one contract to incentivise care to be delivered in the most effective part of the system. However, this does not mean one provider per area. Rather, an average area may see three to four contracts each containing, on average, 55 GP practices and one acute non-specialist trust and one to two mental-health trusts (in 38 areas of the size argued for in Chapter 3). Across the country, this would result in contracts worth on average £755 million a year.[266] To put this in context, Kaiser Permanente, a pioneering US health provider, serving 12 million members, had an annual operating revenue of $64.6 billion in 2016.[267]

There is a supplier base willing to take larger contracts in healthcare. It has been reported that Modality, a large GP federation in the West Midlands hopes to move to London.[268] Another large GP provider interviewed for a previous *Reform* paper spoke of their intention to move into secondary care. Successful international organisations could be encouraged to bid for English contracts. If there are not enough suppliers to yet take single contacts for care across the system, alliance contracts offer the ability for different providers to come together to deliver integrated care. This has been the favoured approach of Canterbury, New Zealand, where primary and secondary care providers have been given single budgets since the early 2000s.[269] Aligning incentives across the system proved successful: in 2011-12, Canterbury was the only District Health Board to receive a "very good" grading from the New Zealand Auditor, a rating it achieved again in 2012-13.[270]

Health contracts, single or alliance, may also include elements of employment or offender-management services. For example, healthcare providers may deliver direct employment services (co-located for example), or may be rewarded for intervening in areas such as mental ill-health with the intention of returning people to employment. Alliance contracts

263 M Gaynor, R Moreno-Serra, and C Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service. Working Paper No. 10/242.*, 2011; Cooper et al., 'Does Hospital Competition Save Lives?'
264 Gaynor, Moreno-Serra, and Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service. Working Paper No. 10/242.*; Kristian Niemietz, *Health Check: The NHS and Market Reforms*, 2014.
265 Gaynor, Moreno-Serra, and Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service. Working Paper No. 10/242.*
266 *Reform* calculations based on 135 contracts in 38 commissioning areas, as set out in Chapter 3.
267 Kaiser Permanente, 'Fast Facts about Kaiser Permanente', Kaiser Permanente Share, 18 March 2016.
268 Nick Renaud-Komiya, 'Exclusive: Vanguard "Super Practice" Bid to Switch CCG Rejected', *Health Service Journal*, 11 March 2015.
269 Nicholas Timmins and Chris Ham, *The Quest for Integrated Health and Social Care A Case Study in Canterbury, New Zealand* (The King's Fund, 2013), 17.
270 Controller and Auditor-General, *Health Sector: Results of the 2011/12 Audits*, 2013, 25; Controller and Auditor-General, *Health Sector: Results of the 2012/13 Audits*, 2014, 29.

are embryonic in the NHS, and so have yet to branch out to other policy areas. Commissioners have come close in Stockport, commissioning an alliance contract held by two local charities, with nursing and social-care workers from Pennine Care NHS Trust co-located with the charities.[271] Outcome aims include improved employment, and the contract is, according to early research, delivering service improvements.[272]

Commissioners and prime providers should be cognisant of the size of the employment-services elements of these contracts. Large contract sizes (and associated requirements of turnover of £20 million or more from providers) reduced the market for bidding for the Work Programme.[273] Commissioners should be aware of size issues if rolling Work and Health Programme and JCP services together, ensuring they work with local providers to gauge the optimum size to enhance competition.

This is not to rule out commissioners contracting for individual services. Employment services, especially if contracted to cover all claimants within a region, could be delivered by single organisations in an area of a region — or across the whole region so long as the supplier base is there to compete for the contracts and contracts do not undermine long-term competition. These contracts should follow the lengths of previously competitive and successful ones. Previous *Reform* research argued that contracts of five to seven years in length struck a balance between incentivising competition and allowing providers time to invest.[274] For offender management, the Peterborough contract spanned five years, with successful returns, and seven-year Transforming Rehabilitation contracts, on average, incentivised at least two providers to bid for each CRC.[275]

Healthcare contracts may vary more. The small number of outcomes-based contracts in England are between three and 10 years in length.[276] It has taken Badalona, in Spain, 16 years to deliver excellent results on services.[277] Elsewhere in Spain, Ribera Salud has been celebrated as delivering better care for less by delivering primary and secondary care in Valencia, holding a 15-year contract, with the option to extend the provision of special services for an extra five years.[278] Research by the LGA shows that providers can get a return on investment for preventing services in less than five years. For example, a "Be Active" programme for 40 to 65-year-olds returned over £20 for every pound spent after five years, and a 50+ employment programme delivered a return on investment of £1.95 for every pound spent after two years.[279] McKinsey proposes five to 10-year contracts for non-elective and complex hospital care.[280]

4.4.1.2 Contracting for outcomes

Paying for outcomes is the most efficient way to drive value for money in public services. Instead of paying for processes, which may not work, outcomes-based contracts will pay only for interventions that work. It is not always as simple as making 100 per cent of payments contingent on outcomes, however (although there are examples of this working): providers will likely need to make upfront investments to deliver services.

Two models of rewarding outcomes can be used. The first is the above payment-by-results model, used successfully for employment services and offender-management programmes in the UK. The second is 'capitation', which is per-person funding (weighted for characteristics), in which providers can keep surplus money to incentivise the most efficient care. Capitation could be seen as input budgeting because it specifies resource based on people, but it rewards outcomes (efficient and effective care) by allowing

271 Michael Clark, Tony Ryan, and Nick Dixon, 'Commissioning for Better Outcomes in Mental Health Care: Testing Alliance Contracting as an Enabling Framework', Mental Health and Social Inclusion 19, no. 4 (2015).
272 Ibid.
273 Hitchcock, Pickles, and Riggs, *The Work and Health Programme: Levelling the Playing Field*.
274 Ibid.
275 National Audit Office, *Transforming Rehabilitation*, 2016.
276 The Health Foundation, *Need to Nurture: Outcomes-Based Commissioning in the NHS*, 2015.
277 Badalona Serveis Assistencials, *Delivering Integrated Care in Badalona: Thoughts after 16 Years of Experience*.
278 NHS Confederation, *The Search for Low-Cost Integrated Healthcare: The Alzira Model – from the Region of Valencia*, 2014, 7.
279 Local Government Association, *Prevention: A Shared Commitment. Making the Case for a Preventative Transformation Fund*, 2015.
280 Dash and Meredith, 'When and How Provider Competition Can Improve Health Care Delivery'.

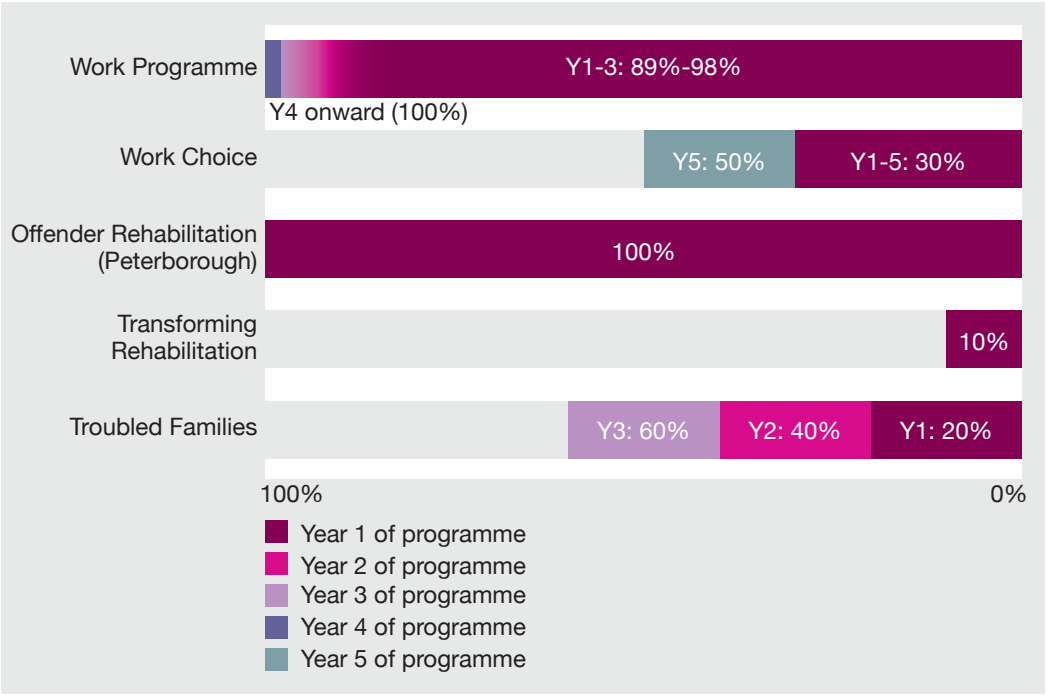
providers to keep the money based on how efficient and effective the care is. Patient choice and entitlements to care (see Chapter 5) also render it unlikely to lead to a race to the bottom where providers deliver the cheapest or minimal care (and this may be a false economy). These models can be combined, and providers should be involved in contract negotiations to find the optimum payment level to incentivise a focus on outcomes, at the lowest cost to taxpayers.

Central-government commissioners have achieved value for money in some outsourced employment-services programmes through payment-by-results models. Work Programme contracts were 89 to 98 per cent funded through outcomes payments for the first three years of the programme, moving to 100 per cent for the remainder.[281] This helped deliver better-than-expected performance on the programme, but poor pricing for certain claimant groups led to creaming and parking, where providers focused on helping claimants closer to the labour market into work. [282] Smaller providers also believed the payments inhibited their market entry, potentially undermining long-term competitive markets.[283] In probation, a 100-per-cent outcomes-based contract for through-the-gate services was piloted in Peterborough between 2010 and 2015, which helped result in a 9 per cent reduction in re-offending.[284]

At the other end of the spectrum, outcomes payments with a lower weighting have not incentivised providers to deliver outcomes. Transforming Rehabilitation's 10-per-cent outcomes-payment weighting, according to HM Inspectorate of Probation and the NAO, in the words of the latter, "limits the incentive on providers to innovate and focus on 'what works' to reduce offending".[285] Work Choice achieved 20 per cent sustained unsupported job outcomes in 2013-14, but it is unclear how much each outcome costs per user and so the value for money is hard to ascertain.[286]

281 Department for Work and Pensions, *The Work Programme: Invitation to Tender*, 2010.
282 Hitchcock, Pickles, and Riggs, *The Work and Health Programme: Levelling the Playing Field*, 22–23.
283 Ibid.
284 Jack Anders and Richard Dorsett, HMP Peterborough Social Impact Bond – Cohort 2 and Final Cohort Impact Evaluation, 2017.
285 National Audit Office, *Transforming Rehabilitation*, 37; HM Inspectorate of Probation, *An Inspection of Through the Gate Resettlement Services for Short-Term Prisoners.*
286 The DWP estimated that, in 2011-12, "Work Choice had an average unit cost of just under £30,000 per paid outcome". Department for Work and Pensions, Residential Training Provision – Independent Advisory Panel Report, 2013.

Figure 29: Outcomes-payments weighting across different services



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

The precise weighting of these payment-by-results contracts will vary. Lessons from best practice suggest that local commissioners of employment and probation services should lean towards the heavier end of the scale, with anything less than 50 per cent appearing hard to justify. Commissioners could move to heavier payments as contracts progress and providers receive payments and scale back on capital investment.[287]

Healthcare funding must align medical and financial incentives. Currently, capitated payments for GPs alongside fee for activity in hospitals creates a perverse incentive for care to be delivered in hospitals. NHS England calls this activity funding payment by results, but this is a misnomer: central fees are applied to the *activity*, such as A&E treatment, or an operation, not the outcome.[288] Likewise, the Quality and Outcomes Framework, a £1-billion annual payment to GPs, dictates that GPs follow specific medical procedures instead of focusing broadly on issues, particularly non-biomedical ones, that may affect an individual's health.[289]

A new offer is needed to incentivise providers to meet patient needs most effectively. Capitated contracts are better applied to healthcare because patients are registered with GPs and therefore known by commissioners. Capitated healthcare contracts incentivise providers to deliver the most efficient care, with savings kept by providers. To achieve this across the system, all providers across the healthcare pathway must be contracted in this way. In the early 2000s, the District Health Board for Canterbury, New Zealand, abolished its activity payments for hospitals in favour of single budgets for providers across the primary and secondary-care systems.[290] Without process measurements, and with contracts stipulating that providers achieve agreed outcomes (as New Zealand prioritises), providers are free to deliver care in the most efficient and effective manner.

287 Hitchcock, Pickles, and Riggs, *The Work and Health Programme: Levelling the Playing Field*, 37.
288 Department of Health, *A Simple Guide to Payment by Results*, 2013.
289 Carolyn A. Chew-Graham et al., 'How QOF Is Shaping Primary Care Review Consultations: A Longitudinal Qualitative Study', *BioMed Central Family Practice* 14, no. 103 (2013).
290 Timmins and Ham, *The Quest for Integrated Health and Social Care A Case Study in Canterbury*, New Zealand, 17.

Commissioners could include outcomes payments in contracts. This would mirror successful capitated plus payment-by-results contracts in the USA.[291] For example, the Alternative Quality Contract in Massachusetts reserves 10 per cent of contract value for defined outcomes and has incentivised better care for less – saving 10 per cent in the fourth year of the contract.[292]

Commissioners also want to incentivise providers to focus on areas of key interest. This may be because they have been elected on a mandate to prioritise certain solutions, for example reducing smoking levels. Or commissioners may integrate policy areas: for example, employment services could be delivered by healthcare providers, which can be included in healthcare contracts. These scenarios could lead to a payment-by-results element being included in larger contracts, tied to wider outcomes.

4.4.1.3 Data sharing

Commissioners need access to data about the needs of residents. Central government has recognised the importance of this, stating in its *Transformation Strategy*: "Delivering public services more effectively and efficiently requires joining together data from multiple public-sector bodies."[293]

Shared data provides at least two important functions. It has the potential to deliver administrative savings through reducing replication of data holding, if designed with this aim at the forefront. For example, Cheshire has created a pan-Cheshire digital care record across two unitary authorities and four CCGs covering 750,000 people.[294] The aim is to provide better information for providers of care in an area in which patients often cross commissioning boundaries.[295] It is anticipated to save £5.3 million across four years.[296]

More profoundly, shared, accessible data allow commissioners to design contracts that can meet the need of residents. Healthcare providers, for example, can use data to segment risk and plan preventative measures based on the risk-assessment of certain residents – targeting high-risk people, for example. In Devon, risk profiling was 87 per cent accurate in predicting unscheduled admissions for the top 200 high-risk patients – allowing providers to take a proactive approach to care management.[297]

Delivering this requires commissioners to have access to shared data, including across healthcare pathways, and including wider information on demographics and labour markets. This is currently available through complex data-sharing methods, which can be streamlined. For example, healthcare data, held separately by trusts and GPs, which is then sent to NHS Digital separately (for example, trusts send clinical commissioning datasets, and GPs send QOF data).[298] These data will not always match similar data from other policy areas, such as criminal justice. Greater Manchester's GM-Connect is attempting to share data between public services across the area (see Box).

291 Zirui Song et al., 'Changes in Health Care Spending and Quality 4 Years into Global Payment', *New England Journal of Medicine* 371, no. 18 (October 2014).
292 Josh Seidman and Nelly Ganesan, *Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract*, 2015.
293 Cabinet Office and Government Digital Service, 'Government Transformation Strategy: Better Use of Data', 9 February 2017.
294 Local Government Association, *Case Study: Cheshire – Setting up a Pan-Cheshire Integrated Digital Care Record*, 2016.
295 Ibid.
296 Ibid.
297 NHS England, *Using Case Finding and Risk Stratification: A Key Service Component for Personalised Care and Support Planning*, 2015.
298 NHS Digital, 'Commissioning Data Sets (CDS)', 24 August 2012. Some CCG have data services (CSUs) that manages their data for them. NHS Digital, 'Data Services for Commissioners', (Webpage), 5 June 2013.

Sharing data: GM-Connect

Greater Manchester launched GM-Connect in April 2016 to break down information silos to design more efficient public services, which improve outcomes for residents through better insights into the types of services needed. This worked with Greater Manchester's aim to integrate health and social care to deliver better value for money in care. The combined authority set out to understand the current arrangements and how they met service-provision needs, identified Greater Manchester-wide requirements and standards to work towards, assessed means to achieving these aims, and procured services to do so. The challenge is to extend this information sharing with other public services, including police services as Greater Manchester Police upgrades its IT infrastructure. The information-sharing portal procured can accommodate up to 1,000 organisations.

Source: Greater Manchester Health and Social Care Partnership Strategic Partnership Board, *Enabling Health and Social Care Reform through Information*, 30 June 2016.

A more profound shift would clarify data ownership, and put it into the hands of citizens. In healthcare, the complex interactions between providers, such as GPs, commissioners, non-departmental bodies such as NHS Digital, and the Secretary of State contributes to confusion about responsibility for patient data. As it stands, it appears the Secretary of State for Health owns patient data, as then Minister of Health, Roland Moyle, explained in Parliament in 1976:

> *Personal medical records, including X-rays, in respect of patients treated under the NHS are held to be the property of the Secretary of State. NHS hospital medical records are stored in premises designated by the appropriate health authority. Access to a patient's medical records is governed in the patient's interest by the ethics of the medical and allied professions.*[299]

The Public Records Act 1958 legislates for the safe keeping of these records and information.[300] The Local Government Act 1972 requires local authorities to manage the documents of public health records and social care records where the local authority is the provider.[301] Neither of these requirements affect the Secretary of State's ownership of health records.

This is technical, but important. It means that the Secretary of State can give patients control of medical records, to then pass to commissioners, without new legislation. In September 2017, Jeremy Hunt committed to giving every patient in England access to medical records by the end of 2018.[302] The next step should be to allow commissioners access to patient information to design contracts, via an opt-out consent form. This was the thinking behind the care.data programme, which warns that policymakers should explain the process better to patients, to ensure that all are aware of the extent to which data are shared and their rights as patients to opt-out.[303]

This personal control and sharing model of data could provide a model for other areas to follow. Data standards should be applied consistently, to ensure that as data are collected by commissioners they can be used in different areas or across the country to build a more comprehensive of people's needs.

299 Roland Moyle, 'Medical Records (Ownership and Storage) HC Deb 30 November 1976 Vol 921 c91W', n.d.
300 HM Government, *Public Records Act 1958*, 1976.
301 HM Government, 'Local Government Act' (1972), Section 224.
302 Laura Donnelly, 'Book an Appointment with Your GP by Smartphone App, under New NHS Plans', *The Telegraph*, 11 September 2017.
303 Nick Triggle, 'Care.data: How Did It Go so Wrong?', *BBC News*, 19 February 2014.

5
The role of the centre

Central government has a crucial role to play in the devolution of public-services commissioning. The arguments for the restructuring of local government and commissioners have been set out. Whitehall will need to change to facilitate the devolution of powers, but it need not be fundamentally restructured for this purpose, in the medium term. Amending the machinery of local commissioning will, in a way, escape this need. But changes should be made. Central government should be clearer about the ambitions of devolution and what is up for grabs for local commissioning bodies. A coordinating and policy unit provide greater clarity, and ministers should be willing to lose control of policymaking and commissioning to local bodies. Whitehall will need to agree funding for local commissioners. It will also have a role in commissioning national services, which should achieve better value for money from the centre.

5.1 Provider of national services

There remain circumstances under which central government should continue to commission services. This is where:

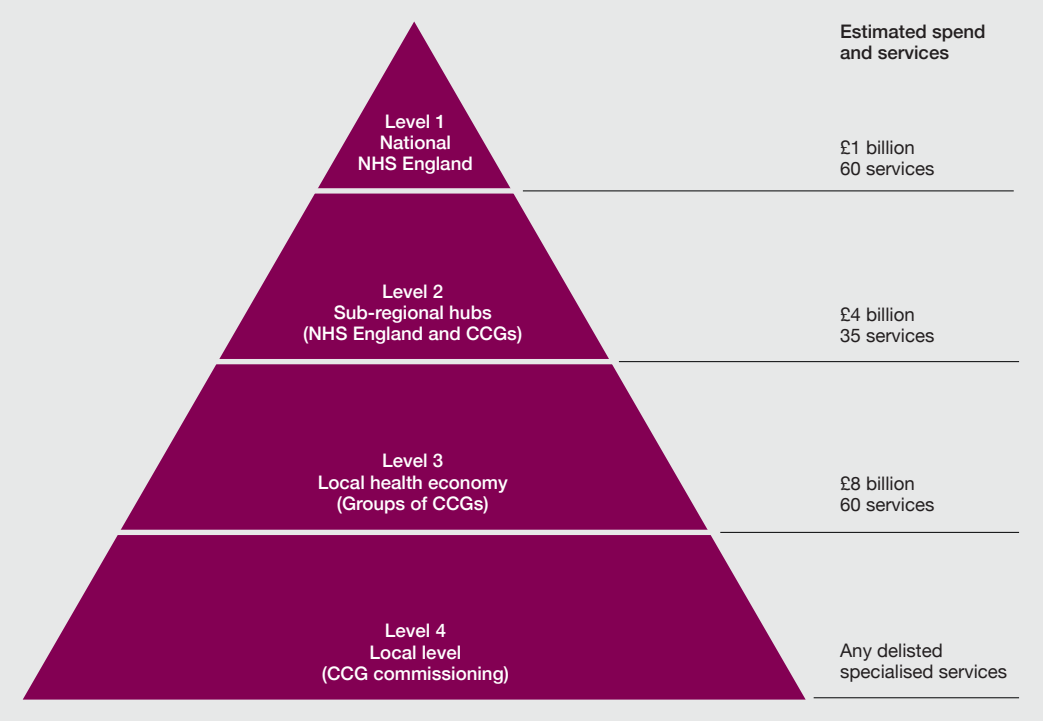
- economies of scale necessary to provide the service at a local level cannot be achieved;
- there is a need for one-size-fits-all approach; and/or
- there is a very small provider market.

5.1.1 Healthcare

5.1.1.1 Specialised health services

Some specialised health services should be commissioned by the Department of Health. The current commissioning of these services is via a complex arrangement of central, regional and local commissioning (see Figure 30).

Figure 30: Commissioning of specialised health services



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

Chapter 2 argues the case for the devolution of level 2 — 4 services, but level 1 should

remain at the centre. The NAO notes that there is a consensus amongst commissioners and providers that NHS England commissions "too many" specialised services, particularly for those with long-term conditions, which can fragment patient pathways.[304] But centralised commissioning has allowed government to drive efficiencies in some areas. For example, NHS England secured an 18 per cent discount on a ten-year contract for PET-CT scans.[305] Nevertheless, the NAO and Public Accounts Committee should continue to investigate whether these 60 services are achieving value for money, when commissioned from the centre, and point to further opportunities for devolution of this commissioning where, for example, economies of scale are no longer achieved at the centre because demand for a service increases sufficiently.

5.1.1.2 Public-health campaigns

Central government should continue to organise public-health campaigns on issues affecting the nation. Past successes suggest that there need not be numerous approaches to delivering these campaigns. Notable successes include HIV/Aids campaigns in the 1980s, designed to stop the spread of the deadly condition. National campaigns are credited with reducing the number of cases of HIV/Aids, with the Terrance Higgins Trust noting that slower reactions from countries like France, Spain and Italy contributed to those nations having twice the number of people with HIV in 2009.[306] The University of Bath finds that television anti-smoking campaigns may have contributed to 11 per cent of the total decline of smoking between 2002 and 2009.[307] Positive effects of national media campaigns have been reported in other areas, including increasing alcohol risk-awareness and use of sun screen to prevent skin cancer.[308]

The Department of Health should continue to commission high-priority public health campaigns nationally. Currently, these include sexual health, smoking cessation, alcohol safety, and mental illness campaigns. This is a small expenditure in the context of NHS spending, at around £42 million per annum.[309]

5.1.1.3 Immunisation programmes

Similarly, vaccinations can be commissioned at a national level. In the UK, vaccinations have eradicated serious conditions and illnesses, such as polio, and virtually eradicated whooping cough, diphtheria and meningitis C.[310] The NHS currently provides these and many others across the country for eligible groups, including for flu, shingles and HPV. [311] Nationally recommended vaccinations are held in Public Health England's *Immunisation Against Infectious Disease* green book.[312] Government currently spends around £600 million a year on immunisation programmes.[313] .

Central procurement of these vaccines allows government to contract multiple suppliers to introduce competition (to the greatest extent possible, in a limited supply side) and ensures that providers can meet demand.[314] Currently, providers such as GPs are rewarded for vaccination coverage – a policy that can be amended at local level depending on benchmarking. Central government could provide a procurement framework for vaccinations, which providers could buy vaccinations from to meet future contractual obligations.

304 Ibid., 30.
305 Ibid., 34.
306 Jon Kelly, 'HIV/Aids: Why Were the Campaigns Successful in the West?', *BBC News*, 28 November 2011.
307 Michelle Sims et al., 'Effectiveness of Tobacco Control Television Advertising in Changing Tobacco Use in England:a Population-Based Cross-Sectional Study', *Addiction* 109, no. 6 (June 2014): 986–94.
308 NHS Health Development Agency, The Effectiveness of Public Health Campaigns, 2004.
309 Public Health England, *Strategic Plan for the next Four Years: Better Outcomes by 2020*, 2016, 22.
310 NHS Choices, 'How Vaccination Saves Lives', 16 January 2017.
311 NHS Choices, 'Vaccination Schedule', 17 August 2017.
312 Public Health England and Department of Health, *Immunisation against Infectious Disease*, 2013.
313 Office for National Statistics, *UK Health Accounts*, 2017.
314 National Audit Office, *Procurement of Vaccines by the Department of Health*, 2003.

5.2 Providing a framework for devolution

Local authorities look to central government for direction. Central government should provide clarity about which powers local commissioners can look forward to taking, as well as outline the Government's expectations for the pace of devolution of public-services commissioning.

5.2.1 Clarity over the devolution agenda

The devolution trade-off is clear. Allowing local commissioners to take responsibility for commissioning services whenever and however they wish risks creating a patchy, inefficient and even confusing devolution arrangement — one in which local areas are unclear about opportunities and expectations. Yet, Whitehall driving through devolution is a clear example of central control, and will likely result in a lack of buy-in from local commissioners. For example, government's requirement for a mayor was seen by one council CEO as "the clearest example of central-government control."

A middle ground is needed. Local authorities across the country interviewed for this paper argued that freedom to come up with devolution plans is crucial to allow local areas to organise powers as they see fit. But local areas want greater clarity over central government aims for devolution – in particular over how far ministers are willing to devolve powers, and how these will be facilitated. The example of integrating health and social care (a government aim) was provided by one unitary authority: council leaders wanted clarity over how health and social-care commissioning and funding would be aligned to achieve this. This echoes recent literature.[315]

5.2.1.1 The Devolution Unit: formalising public-services-commissioning devolution

Achieving this middle ground requires government to outline the public services it is willing to devolve, while setting out timeframes for the transfer of funding, people and power. One interviewee called for a royal commission on devolution, but more practical steps should be taken. Legislative change to facilitate devolution would provide clarity over the ability to change commissioning bodies.

Devolution should be achieved in a structured way to allow central government to work most efficiently when transferring powers. As it stands, policy is seen to be "informal" and ad hoc, with social relationships playing a significant role in policymaking.[316] This has benefits, as it allows for the emergence of bespoke devolution deals, but it is not the most effective way to manage devolution across England.[317] One solution could be an expansion of the Cities and Local Growth Unit to work with local areas to develop devolution plans to include public-service commissioning. This Unit has had positive feedback in managing the devolution process, on behalf of HM Treasury, the Department for Business, Energy and Industrial Strategy, DCLG and DWP.[318]

This would be a much-expanded role for the Cities and Local Growth Unit, which should be renamed the Devolution Unit. The NAO has previously cited concerns from local authorities that the Unit may not have the influence across Whitehall to drive devolution.[319] Expanding its role, to allow it to coordinate the devolution of public-service commissioning, would change this. Commissioners from central-government commissioning teams whose functions are devolved could move to this Unit. Officials should be drawn in from other relevant departments, including Ministry of Justice, Department for Education, Department of Health and Cabinet Office.

315 House of Commons Committee of Public Accounts, *Cities and Local Growth. Sixth Report of Session 2016–17*, 2016.
316 Political Studies Association Research Commission, *Examining the Role of 'informal Governance' on Devolution to England's Cities'* (Political Studies Association, 2016).
317 Ibid.
318 National Audit Office, *English Devolution Deals*, 2016.
319 Ibid., 12.

The Devolution Unit should also work with local areas to devolve services in tranches, along the lines of the timeframes set out in Section 2.4. This would not only provide clarity over the process of devolution, but allow the Unit to most efficiently manage simultaneous devolution deals — mitigating a concern the NAO has previously raised of the Cities and Local Growth Unit.[320]

Recommendation 9: The Government should expand the role of the Cities and Local Growth Unit to include oversight of the devolution of public-services commissioning. The new unit should be called the Devolution Unit with wider membership from all departments from which powers are devolved.

5.2.1.2 Leadership at the centre

Leaders are much needed to set out this vision. One Council CEO described NHS England's leadership as "not good enough" because leaders were perceived as being unclear over what they mean by saying: "you go away and look for the answer but it mustn't look like this that or the other". Other interviewees pointed to specific permanent secretaries stalling devolution.

Having a central figurehead is crucial. As Chancellor of the Exchequer, George Osborne embodied the Northern Powerhouse, and put economic devolution on the agenda for other parts of the country by, in his own words, "starting the conversation about serious devolution of powers and budgets for any city that wants to move to a new model of city government".[321] For the devolution of public-services commissioning, the role should be taken up by someone as senior. This should be the Prime Minister — a national figure head who can unify both the growth agenda and the devolution of public-services commissioning. Devolution in Japan was driven by Prime Ministers.[322] Such a leader can set out a long-term programme of devolution, which could extend to fiscal devolution, as in Japan.[323]

Ministers must also drive through devolution. The Secretary of State for Health should champion NHS devolution policy, which overrules the centralising tendencies of NHS England. Likewise, the Work and Pensions Secretary can drive the devolution agenda in the department. Japan benefitted from a whole governing party committed to devolution.[324]

5.2.2 Block-grant funding: giving local commissioners control

Currently, public-services funding is distributed in highly complex ways – between central government departments, central government and providers, central government and local commissioners, local commissioners and providers.[325] This creates fragmented streams of funding, with different bodies commissioning services used by the same citizens.

Simplification is needed. It will be aided by consolidated governance structures. It can only be fully achieved through fair funding settlements, which allow local commissioners to act with freedom to achieve the best outcomes within budgets.

One method is the introduction of block grants for devolved commissioning. Block grants have long been supported as means of providing local decisionmakers space to design services responsive to local citizens' needs.[326] Proponents argue that these grants can

320 National Audit Office, *English Devolution Deals*, 32.
321 George Osborne, 'We Need a Northern Powerhouse', Speech, (23 June 2014).
322 Brendan Barrett, 'Decentralization in Japan: Negotiating the Transfer of Authority', *Japanese Studies* 20, no. 1 (2000).
323 PwC, *Beyond Letting Go: The Role of Central Government in a Decentralised World*, 2013, 7–8.
324 Barrett, 'Decentralization in Japan: Negotiating the Transfer of Authority'.
325 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*, 20.
326 Margy Waller, 'Block Grants: Flexibility vs. Stability in Social Services', *The Brookings Institution Policy Brief: Center on Children & Families* 34 (December 2005): 3.

reduce administrative spend through reducing the need for central decisionmakers on top of local managers.[327] Block grants also provide a clarity over spend, which can incentivise restraint. The ability to design funding models, and financial responsibility for their success, would focus minds to overcome the inclination to see centrally funded projects as Whitehall's problem.[328] Central government must distribute block grants on the simple condition that local commissioners achieve high-level outcomes set by the centre (see Section 5.2.3.2). How this is achieved by local commissioners should be local commissioners' responsibilities.

How these grants are calculated will be negotiated between central government and local commissioners. It can follow current approaches in England and the UK. Block grants should follow the principle of distributing money based on need, as council grants have since 1929 — with need being defined through demographic, economic and social data. This should be expanded to include health needs, for which the funding fundamentals are in place. The NHS's capitated funding system, for example, weights GP payments based on patient characteristics.[329]

These funding streams can be improved. For example, the formula underpinning GP payments does not fully reflect the extent to which deprivation increases demand.[330] This should be investigated by a UK Funding Commission, as argued for by a 2009 House of Lords Select Committee to improve the Barnett formula for Scotland, Wales and Northern Ireland by introducing a needs-based approach.[331]

This Commission should learn from international practice to ensure this funding remains stable and fair. Grants should be at the very least inflation linked — preferably to a bespoke measure of inflation which takes into consideration the inflationary pressures on healthcare in particular.[332] Reduction in real-terms funding as a result of inflation has been a hallmark of USA block grants, and can be avoided with planning. With information on the inflation of healthcare other services, the UK Funding Commission could develop the index for these block grants.

Block grants should also be distributed for multiple years. STPs offer two-year funding packages, which, international examples cited above suggest, may not incentivise systemic transformation of healthcare in Egland. Employment services contracts have lasted longer: the Work Programme will have run for six years, and the Work and Health Programme is expected to run for five.[333] This suggests that block grants should be granted for around five years to local commissioning bodies. Four years would align with most council election cycles, and could incentivise provider investment and healthy competition.

These grants should be singular and not ring fenced. Ring-fenced budgets would undermine the ability of local commissioners to devise contracts to meet outcomes. The Taylor Review, for example, called for grants for youth offender teams to remove its ring fence to allow local authorities discretion over spend, despite the teams being successful in many cases.[334]

Further ahead, the door should remain open for fiscal devolution. Councils are taking increasing control of locally raised taxes – keeping 100 per cent of business rates in 2020.[335] Scotland and Wales are getting increasing responsibility over raising and keeping local spend – including elements of income tax and receipt of half the share of VAT

327 Ibid.
328 Harwich, Hitchcock, and Fischer, *Faulty by Design. The State of Public-Service Commissioning.*
329 Monitor, *Capitation: A Potential New Payment Model to Enable Integrated Care*, 2014.
330 Ewbank, Hitchcock, and Sasse, *Who Cares? The Future of General Practice* (Reform, 2016), 16.
331 Ibid.
332 Anita Charlesworth, 'Why Is Health Care Inflation Greater than General Inflation?', *Journal of Health Services Research & Policy* 19, no. 3 (2014): 129–30.
333 Hitchcock, Pickles, and Riggs, *The Work and Health Programme: Levelling the Playing Field* (Reform, 2016), 30.
334 Taylor, *Review of the Youth Justice System in England and Wales*, 13.
335 Department for Communities and Local Government, *100% Business Rates Retention. Further Consultation on the Design of the Reformed System*, 2017.

receipts.[336] In 2014, the Communities and Local Government Select Committee argued for fiscal powers to be devolved to "groups of local authorities, covering a recognisable largescale area, that can demonstrate how they share, and work together as, a functioning economy."[337] In the context of commissioning, a compelling case can be made for this providing greater responsibility and accountability for public spend. There are fundamental issues to be addressed, around equalisation, for example, before this can become a reality. These cannot be addressed here, but government should be open to devolving fiscal powers as the final stage of devolution.

Recommendation 10: Local commissioning bodies should receive block-grant funding. Local commissioning bodies should only be required to meet high-level outcomes agreed with the centre to receive the funds, and the grants should cover five-year periods. Block grants should be inflation linked and the inflation index and funding formula set by a UK Funding Commission.

5.2.3 Central conditions

Central government can also remove the possibility of a race to the bottom of devolved commissioning, whereby local areas remove services for certain groups to save money, for example. Citizens should be entitled to receive general services, without this prescribing what local providers should deliver. Devising high-level outcomes to guide local commissioners will help consistency of outcomes across the country.

5.2.3.1 Entitlements

The centre should ensure that people have access to services to meet needs. In the NHS, the Department of Health's NHS Constitution for England fulfils this function. It provides for seven principles that guide the NHS, as well as NHS values and the rights and responsibilities of patients and staff.[338] This is a clear document, which effectively codifies the key principles of the NHS and should remain in place to guarantee the fundamentals of healthcare access and delivery across England.

Retaining this constitution when devolving healthcare commissioning should be accompanied by the NHS stripping back entitlements which would undermine the tailoring of healthcare to local areas. An example is the right to a named GP for all patients, which fails to recognise that healthcare can be delivered by other professionals.[339]

Other devolved services should follow this approach. Jobseekers should be guaranteed access to employment-services programmes – that is, not a specific programme, but however so designed in the area. The centre should also guarantee basic benefits entitlements, along the lines currently prescribed – that is, ultimately, through Universal Credit. The base rates of these benefits should be consistent across England and Wales.

Local areas should, however, have freedom to apply benefit sanctions and implement compulsory schemes, from work experience to employment-services programmes. The current aim of these arrangements is to reward work and incentivise people to enter the labour market. As Chapter 2 argued, however, this is best achieved through local policy making.

336 BBC News, 'What Are Scotland's Tax Powers?', 30 November 2016, sec. Scotland politics.
337 House of Commons Communities and Local Government Committee, *Devolution in England: The Case for Local Government*, 2014, 2.
338 Department of Health, The NHS Constitution for England, 2015.
339 BMA, 'GP Contract Named GP', 30 June 2016; Ewbank, Hitchcock, and Sasse, *Who Cares? The Future of General Practice*.

5.2.3.2 Outcomes

Chapter 2 argued that local commissioners are best-placed to set outcomes for programmes designed to meet needs in the region. This can be complemented by central government setting higher-level outcomes, to steer local policy in the right direction and provide ministers with clarity and confidence that local commissioners are achieving agreed goals. As Charlie Taylor rightly argues, "government should be clear about what it wants local authorities to achieve, but not how they are to achieve it."[340]

Again, government can refine current arrangements to set these outcomes. In healthcare, the NHS has a series of fundamental aims, which were deemed sensible by healthcare commissioners interviewed for this paper (see Figure 31). The only point of contention was why there are separate health, public-health and social-care aims, as well as other documents setting out aims, such as the NHS mandate. As the areas are integrated, ministers could amalgamate these to provide clear and consistent aims across two policy areas. This is not least because some overlap.

Figure 31: NHS outcomes framework

Outcomes framework	Outcome 'domains'
NHS	Preventing people from dying prematurely
	Enhancing quality of life for people with long-term conditions
	Helping people to recover from episodes of ill health or following injury
	Ensuring that people have a positive experience of care
	Treating and caring for people in a safe environment and protecting them from avoidable harm
Public health	Improving the wider determinants of health
	Health improvement
	Health protection
	Healthcare public health and preventing premature mortality
Adult social care	Enhancing quality of life for people with care and support needs
	Delaying and reducing the need for care and support
	Ensuring that people have a positive experience of care and support
	Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Sources: Department of Health, *NHS Outcomes Framework 2016 to 2017*, 2016; Department of Health, *Improving Outcomes and Supporting Transparency*, 2016; Department of Health, *The Adult Social Care Outcomes Framework 2016/17: Handbook of Definitions*, 2017.

Other areas can similarly set a small number of high-level outcomes. In 2012, the DWP set five aims as part of its Social Justice Outcomes Framework. These are: supporting families; keeping young people on track; the importance of work; supporting the most disadvantaged adults; and delivering social justice.[341] These general outcomes have been used to devise contracts, such as for the Work Programme, which tied payments to outcomes. The Ministry of Justice has set aims for prison services: protect the public; maintain safety and order; reform offenders to prevent more crimes being committed; and prepare prisoners for life outside of prisons.[342] However, there does not appear to be single outcomes set by the Ministry to focus all policy on and therefore devolved commissioning.

340 Charles Taylor, *Review of the Youth Justice System in England and Wales* (Ministry of Justice, 2016), 12.
341 HM Government, *Social Justice Outcomes Framework*, 2012.
342 Ministry of Justice, *Prison Safety and Reform*, 2016.

Other countries operate with a small number of central aims. In the early 2000s, Australia replaced 1,000-page central government targets for commissioners with 20-page statements of priorities.[343] These have 20 or 30 key performance indicators, which have provided health providers with space to innovate.[344] In Denmark, the minister sets three or four national employment goals, which are interpreted by local governments based on their applicability to the different areas.[345]

New Zealand has gone further to set cross-cutting outcomes at the centre, along five different areas:[346]

1. Reducing long-term welfare dependence
2. Supporting vulnerable children
3. Boosting skills and employment
4. Reducing crime
5. Improving interaction with government

Within each of these areas there are two high-level outcomes, and progress against these outcomes is tracked in a transparent way. For example, one of the outcomes that comes under the "reducing long-term welfare dependence" banner is the reduction of the number of individuals who have been on working age benefits for more than 12 months.[347]

This approach has focused government attention on achieving priority outcomes and allowed agencies the space to deliver them. Digestible, public aims allow citizens to monitor government's success in achieving key policy aims, with groups of ministers held to account for outcomes. Evidence points to these outcomes contributing to government's success in achieving them – with three targets being achieved before they were due to.[348]

The UK Government should therefore set a small number of priority outcomes targets across public services, with progress outcomes measures attached. These progress outcomes could be limited to five per policy area, totaling five headline outcomes targets and no more than 25 progress outcomes target across all public services.

5.2.4 Sharing best practice

Central government can also be a repository for best practice, to be shared amongst commissioners. Interviewees for this paper echoed previous research by arguing that information about best practice in local commissioning has not been shared most effectively.[349] Using central government may not be a panacea, but it can provide a simple space for local commissioners to access information. As the Institute for Government noted for the devolved countries in the UK, poor information sharing misses an opportunity to spread innovative practices.[350]

Achieving this means building on and streamlining current processes. As it stands, there are numerous vehicles to share good practice between local commissioners, across policy areas. One popular approach is to use 'what works centres' (see Figure 32).

343 Chris Ham and Nicholas Timmins, Managing Health Services through Devolved Governance. A Perspective from Victoria, Australia, 2015, 19.
344 Ibid.
345 Froy et al., *Building Flexibility and Accountability Into Local Employment Services: Synthesis of OECD Studies in Belgium, Canada, Denmark and the Netherlands*, 39.
346 State Services Commission, 'Better Public Services', 7 August 2013.
347 Ibid.
348 Rodney Scott and Ross Boyd, *Interagency Performance Targets. A Case Study of New Zealand's Results Programme* (IBM Centre for the Business of Government, 2017), 48.
349 Alice Lilly, 'The Role of Whitehall in a More Devolved England', *The Institute for Government*, 17 March 2016.
350 Akash Paun, Jill Rutter, and Anna Nicholl, *Devolution as a Policy Laboratory: Evidence Sharing and Learning between the UK's Four Governments*, 2016.

Figure 32: What works centres

What work centres	Policy area
National Institute for Health and Care Excellence	Health and social care
Sutton Trust/Education Endowment Foundation	Educational Achievement
What Works for Crime Reduction	Crime reduction
Early Intervention Foundation	Early intervention
What works Centre for Local Economic Growth	Local economic growth
Centre for Ageing Better	Improved quality of life for older people
What Works Centre for Wellbeing	Wellbeing

These hold a positive ambition: to develop evidenced-based policymaking to understand both successful and unsuccessful approaches in a host of areas. For devolution, they are not cutting through, however. One reason, according to one interviewee in local government is that local government does not set out its research agenda clearly. These are also one part of a saturated landscape of databanks. The LGA, for example, runs a Knowledge Hub, and other LGA-affiliated networks such as the County Councils Network.

Central government can therefore be more intelligent in its sharing of best practice for devolution areas and areas embarking on devolution. A cross-cutting devolution knowledge bank should be provided under the guise of the Devolution Unit, with the input of third-party experts, such as academics and the LGA. It should also be guided by areas which local areas need information in. The Devolution Unit should develop this in a way that is most useful for local government – either a basic repository of good practice, or a more substantial unit, which involves a wider range of people and produces policy reports and recommendations for local commissioners. The latter would be akin to the Government's Social Exclusion Unit (albeit for local government), which ran from 1997 to 2007, working on a range of issues that caused social ills – from rough sleeping to jobs in deprived areas – producing repots, often with detailed recommendations that sometimes resulted in government initiatives.[351]

351 Sophie Wilson et al., *Joining up Public Services around Local, Citizen Needs* (Institute for Government, 2015), 14.

Conclusion

Just as governments have created the complex, fragmented, one-sized-fits-all commissioning approaches outlined in *Faulty by design,* governments can fix it. This might take 15 years, but it requires a clear focus from the off.

This paper hopes to provide this focus for policymakers. Public services in healthcare, employment, skills and offender management are ripe to be devolved. In total, this would see a dramatic shift of taxpayer money – north of £100 billion. It should streamline administration, and allow commissioners to work with public-service providers to design higher-value solutions. This matters because the most immediate beneficiaries would be the most vulnerable in society: the elderly person with several chronic health conditions, the long-term-unemployed single parent, the homeless person looking to get their life back on track.

Government must be brave to drive the legislative and cultural change necessary to make this work. But it would be working with the grain: recent governments have set the devolution ball in motion, and the governance structures necessary already exist. This provides an important platform from which government, at all levels, can provide a vision; a vision for more effective public services that work for all.

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