Derby City Council

January 2015

HEALTH AND WELLBEING BOARD: POLICY UPDATE

Derby Health and Wellbeing Board has a responsibility to lead and advise on work to improve the health and wellbeing of the population of Derby and specifically to reduce health inequalities. It also has a remit to support the development of improved and joined up health and social care services.

This briefing provides the Board with an overview and update of some of the Government's current health and social care policies and policy shapers thinking, to support the Board in delivery of these responsibilities.

1. **Spending Review and Autumn Statement 2015 (Nov 2015)** sets out a, "…long term economic plan to fix the public finances, return the country to surplus and run a healthy economy that starts to pay down its debt". This has significant implications for the local health and social care system.

2. **The Spending Review: What Does it Mean for Health and Social Care? (Dec 2015)** a briefing prepared by the Nuffield Trust, The Health Foundation and The King's Fund provides an assessment of where the Spending Review leaves the NHS and social care.

3. **Delivering the Forward View – NHS Planning Guidance 2016/17-2020/21 (Dec 2015) -** sets out the requirements and expectations of the NHS for the coming five years.

4. **Place-based Systems of Care (Nov 2015) -** proposes that providers of services should establish place-based 'systems of care' in which they work together to improve health and care for the populations with organisations working collaboratively to manage the resources available to them. It is expected that this will require a fundamental change to the role of commissioners.

5. **Shared Principles for Redesigning the Local Health and Care Landscape (Sep 2015) -** the NHS Five Year Forward View sets out a vision for the future of the NHS. To deliver this, it suggests that new models of care and delivery are needed. What these models are and how successful they are, is significantly important to both the national and local direction of the health and social care system.

6. **Options for Integrated Commissioning (June 2015) -** the devolution of responsibilities from central to local government and local areas is one of the Government's key policies. A number of devolution deals have already been agreed. Whilst the majority of the deals predominantly focus on transport; business; further education and skills; infrastructure and planning, some, most notably Greater Manchester, also include the devolution of health and social care.

7. **Minimum/ maximum CCGs -** a national commissioning strategy is being drafted by NHS England and is expected to set out potential future scenarios for the role and function of clinical commission groups (CCGs). This is thought to re-define the boundary between provision and commissioning.

Key issues and recommendations

Health and care budgets

- The Spending Review sets out real-terms NHS funding increases in the coming five years, with a significant chunk in 2016/17.
- The establishment of the social care precept and continuation and increase in the Better Care Fund provides further local social care funding.
- There are, however, to be annual real-term savings of 3.9% to public health spending.
- The option for local authorities to fully fund their public health spending from their retained business rates receipts will be consulted on.
- The net impact locally of these proposals is not yet fully known nor the likely impact on local health and social care.

System change

- There is a requirement that local plans are in place by 2017 for health and social care integration and that they are implemented by 2020.
- It is likely that there will be a 'mixed model' of approaches to integration and commissioning, with no centrally imposed model, although the Government supports models such as Accountable Care Organisations and devolution.
- There is currently a significant move towards 'place-based' systems of care and commissioning.
- Options for integrated commissioning could include either the local authority or CCG taking lead responsibility and accountability or Health and Wellbeing Boards taking on the responsibility (although it is recognised that Health and Wellbeing Boards would need evolve to be able to take on such responsibilities).
- It is anticipated that boundaries between provision and commissioning will diminish in the near future, with commissioning becoming a more 'strategic' function over a larger geography.
- The local NHS must develop, by June 2016, a five-year Sustainability and Transformation Plan (STP).

Recommendations

- The Health and Wellbeing Board should seek to understand the local system-wide financial challenges and implications for 2016/17 and future years.
- The Health and Wellbeing Board should facilitate the development of a shared local vision of integrated health and care, integrated commissioning and health and care transformation.
- To consider at what geography local integration, commissioning and transformation should be appropriately defined. A 'transformational footprint' on which the STP will be based must be submitted by 29th January 2016.

1 Spending Review and Autumn Statement 2015

On the 25th November 2015, the Government issued the Spending Review and Autumn Statement 2015. It sets out a, "…long term economic plan to fix the public finances, return the country to surplus and run a healthy economy that starts to pay down its debt" (p.1). Included within this are the Government's proposals to establish a 'sustainable health and social care system'. Key announcements of the Spending Review relevant to the Health and Wellbeing Board include:

- The ***NHS will receive £10 billion*** more in real terms by 2020-21 than in 2014-15, with £6 billion available by the first year of the Spending Review so that the government fully funds the NHS's own Five Year Forward View.
- The government will make ***savings in local authority public health spending***. The government will also consult on options to fully fund local authorities' public health spending from their retained business rates receipts, as part of the move towards 100% business rate retention. The ring-fence on public health spending will be maintained in 2016-17 and 2017-18.
- To continue to reform the public health system, an average ***annual real-terms savings of 3.9%*** is to be delivered over the next five years.
- The Spending Review creates a ***social care precept*** to give local authorities who are responsible for social care the ability to raise new funding to spend exclusively on adult social care. The precept will work by giving local authorities the flexibility to raise council tax in their area by up to 2% above the existing threshold.
- The government will continue the ***Better Care Fund***, maintaining the NHS's mandated contribution in real terms over the Parliament. From 2017 the government will make funding available to local government, worth £1.5 billion in 2019-20, to be included in the Better Care Fund.
- The Spending Review sets out a plan that by ***2020 health and social care are integrated across the country***. Every part of the country must have a plan for this in 2017, implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution. The Government will not impose how this is delivered. There are, however, a number of models in existence which the Government supports, including:
    - ***Accountable Care Organisations*** (e.g. Northumberland);
    - ***Devolution*** deals (e.g. Greater Manchester);
    - All health and social care funding under a ***single local plan*** (e.g. Lead Commissioners such as the NHS in North East Lincolnshire).
- The ***devolution revolution*** sets out a new deal for local government. It requires local authorities to make efficiency savings whilst offering new levers of power to generate growth for their area. The government will allow local government to keep the rates they collect from business, give councils the power to cut business rates to boost growth, and give elected city-wide mayors the power to levy a business rates premium for local infrastructure projects – with the support of local business.
- By the end of the Parliament ***local government will retain 100% of business rate*** revenues to fund local services, giving them control of £13 billion of additional local tax revenues, and £26 billion in total business rate revenues.
- A new statutory duty is to be introduced mandating that ***emergency services collaborate*** by early 2017, subject to parliamentary approval, on areas such as procurement, new

stations and vehicle maintenance

- Legislation is to be brought forward to enable ***Police and Crime Commissioners*** to take on responsibility for ***fire and rescue services***.

Local implications and considerations

- The Health and Wellbeing Board needs to review and understand the implications of the actions outlined above, and in particular:
    - Understand the net financial implications to the local health and social care system of the changes to health and social care funding.
    - Develop a view as to the model of integration of health and social care most appropriate for the local system.

References

HM Treasury (2015) *Spending Review and Autumn Statement 2015*. HM Treasury, London.

2 The Spending Review: what does it mean for health and social care?

Following the publication of the Spending Review 2015, the Nuffield Trust, The Health Foundation and The King's Fund released *The Spending Review: what does it mean for health and social care?* a briefing paper to set out an independent assessment of what the Review means for health and social care.

Previously, 'NHS' funding referred to the totality of the Department of Health's spend. In this Spending Review, however, this refers only to NHS England's budget excluding public health, education and training, capital and national bodies such as the Care Quality Commission (CQC) and the National Institute for Health and Care Excellence (NICE). Key points include:

- Using the previous definition, the real terms increase to health spend is estimated to be £4.5bn;
- Front-loading of the NHS increases, whilst welcome, will mean minimal increases in 2018/19 and 2019/20 will significantly stretch budgets;
- Public health spending will fall by at least £600 million in real terms by 2020/21, on top of £200 million already cut from this year's budget;
- Public spending on health in the UK as a proportion of GDP is projected to fall to 6.7 per cent by 2020/21, leaving us behind many other advanced nations;
- New powers to raise Council Tax by up to 2 per cent to spend on social care will provide flexibility for local authorities but could disadvantage deprived areas with low tax bases;
- The additional funding will not be enough to close the social care funding gap which we estimate will be somewhere between £2 billion and £2.7 billion in 2019/20, depending on how much is raised through the Council Tax precept;
- Social care also faces additional cost pressures from implementing the National Living Wage which will add another £800 million to these estimates, leaving an estimated total funding gap of between £2.8 billion and £3.5 billion by the end of the parliament;
- Public spending on social care as a proportion of GDP will fall back to around 0.9 per cent

by 2019/20, despite the ageing population and rising demand for services.

Local implications and considerations

- The Health and Wellbeing Board needs to consider how the likely financial implications and challenges outlined in the briefing will impact locally.

References

Nuffield Trust, The Health Foundation & The King's Fund (2015) *The Spending Review: what does it mean for health and social care?* Briefing Paper, December 2015.

3 Delivering the Forward View – NHS Planning Guidance 2016/17-2020/21

In December 2015, the NHS published its planning guidance Delivering the Forward View – NHS Planning Guidance 2016/17-2020/21 which sets out, "...a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules". The NHS is required to produce:

- **A five-year Sustainability and Transformation Plan (STP)** – this must be 'place-based' setting out the transformational 'footprint' and will be judged on their quality; ambition; reach (including community, voluntary sector and local authority engagement); strength and unity of local system leadership and partnership. This plan will also be the means by which to secure transformational funding from 2017/18 onwards.

  Monitor has prepared geographical maps and resources to support (not prescribe) local discussions to determine their planning footprints. Based on this research, it defines Derbyshire as a potential 'local area'.

  It emphasises the need to plan 'by place' for local populations rather than only by individual organisation. New care models are expected to feature prominently within STPs.

  Further guidance is to be issued in relation to the development of STPs. In the interim, however, this documents highlights a number of questions or 'national challenges' that "...give an early sense of what you will need to address to gain sign-off and attract additional national investment":

  - **How will you close the health and wellbeing gap?** To include plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.
  - **How will you drive transformation to close the care and quality gap?** To include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.
  - **How will you close the finance and efficiency gap?** To describe how financial balance across the local health system and how the efficiency of NHS services will be achieved.

- **One-year Operational Plan for 2016/17** – whilst this should be organisational based, it must be consistent with the emerging STP and should be considered as year one of the STP.

As well as developing a local five year STP an operational plan, there are nine national 'must do's' for every local system:

1. Develop a high quality and agreed STP;
2. Return the system to aggregate financial balance;
3. Develop and implement a local plan to address the sustainability and quality of general practice;
4. Get back on track with access standards for A&E and ambulance waits;
5. More than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment;
6. Deliver the 62 day cancer waiting standard; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates;
7. Achieve and maintain the two new mental health access standards;
8. Transform care for people with learning disabilities;
9. Develop and implement an affordable plan to make improvements in quality.

Key dates

29th January - Localities to submit proposals for STP footprints;

8th February - First submission of full draft 16/17 Operational Plans;

11th April - Submission of final 16/17 Operational Plans, aligned with contracts;

End June - Submission of full STPs;

End July - Assessment and Review of STPs.

Local implications and considerations

- The Board should consider its input and influence into the STP footprint and its role into the development and implementation of the STP.

References

NHS England, NHS Improvement, Care Quality Commission, Health Education England, National Institute of Health and Care Excellence and Public Health England (2015) *Delivering the Forward View – NHS Planning Guidance 2016/17-2020/21*. December 2015, Gateway Reference: 04437.

Monitor (2015) *Considerations for Determining Local Health and Care Economies*. Monitor (December 2015) Publication code: IRG 44/15

4 Place-Based Systems of Care

The King's Fund recently published the report, 'Place-based systems of care: A way forward for the NHS in England'. This report proposes that providers of services should establish place-based 'systems of care' in which they work together to improve health and care for the populations they serve. This means organisations collaborating to manage the common resources available to them to develop 'systems of care'. It suggests that the following needs to be in place:

- Developing an appropriate governance structure;
- Putting system leadership in place;
- Developing a sustainable financial model.

The report proposes that, "Fundamental changes to the role of commissioners are needed to support the emergence of systems of care. Commissioning in future needs to be both strategic and integrated, based on long-term contracts tied to the delivery of defined outcomes. Scarce commissioning expertise needs to be brought together in footprints much bigger than those typically covered by clinical commissioning groups (CCGs), while retaining the local knowledge and clinical understanding of general practitioners (GPs)" (p.3).

Proposals are to:

- avoid place-based discussions descending into a zero-sum game that inhibits the development of collaborative working between local NHS leaders
- develop new care models that span organisational and service boundaries, supported by new approaches to commissioning and paying for care
- establish robust governance arrangements that balance organisational autonomy and accountability with a commitment to partnership working and shared responsibility
- develop services that are financially and clinically sustainable through greater integration of care and a focus on improving population health and wellbeing
- provide a foundation for collaboration with a wider range of organisations from different sectors
- put in place the leadership required to work in this way by sharing expertise and skills in different organisations
- work in partnership with the public and local communities to transform the way that services are delivered
- enable national bodies to work differently and in a joined-up way to support providers and commissioners in finding solutions to their challenges.

The paper sets out ten principles to guide the development of systems of care:

1. Define the population group served and the boundaries of the system.
2. Identify the right partners and services that need to be involved.
3. Develop a shared vision and objectives reflecting the local context and the needs and wants of the public.
4. Develop an appropriate governance structure for the system of care, which must meaningfully involve patients and the public in decision-making.
5. Identify the right leaders to be involved in managing the system and develop a new form of system leadership.
6. Agree how conflicts will be resolved and what will happen when people fail to play by the agreed rules of the system.
7. Develop a sustainable financing model for the system across three different levels:
   - the combined resources available to achieve the aims of the system
   - the way that these resources will flow down to providers
   - how these resources are allocated between providers and the way that costs, risks and

rewards will be shared.

8. Create a dedicated team to manage the work of the system.
9. Develop 'systems within systems' to focus on different parts of the group's objectives.
10. Develop a single set of measures to understand progress and use for improvement.

Place-based systems of care require fundamental changes in the role of commissioners. The report also suggests that commissioning should be seen primarily as a strategic function (funding, planning and holding providers to account) that brings together scarce expertise and that commissioning also needs to be integrated, including between the NHS and social care, to enable greater collaboration between providers.

Local implications and considerations

- It will be necessary to develop a local view of what a 'placed based' system of care would look like locally.
- Consideration needs to be given to what geography would be an effective commissioning 'footprint' locally.
- Need to consider how to work in partnership with the public and local communities to transform service delivery.

References

Ham, C. & Alderwick, H. (2015) *Place-based systems of care: A way forward for the NHS in England*. King's Fund, London.

5 Shared Principles for Redesigning the Local Health and Care Landscape

In September 2015, the Local Government Association in partnership with a number of partners, published Shared Principles for Redesigning the Local Health and Care Landscape. This short document sets out five key principles to support local system leaders in ensuring service redesign are focused on improving services and achieving health and wellbeing outcomes with a focus on co-creation and co-design. The principles provide a framework against which to test proposals. The five principles are:

1. Do the proposals promote a person centred approach?
2. To what extent are they rooted in local accountability?
3. Are the proposals evidence based?
4. Do the proposals promote a place based community budgeting approach?
5. Will they make a difference?

Local implications and considerations

- To consider testing current and future plans for health and care against the five principles.

References

Local Government Association (2015) *Redesigning the Local Health and Care Landscape*. Local Government Association, London.

6 Options for Integrated Commissioning

The King's Fund published the report Options for Integrated Commissioning in June 2015. It follows up on the 2014 Barker Commission report A New Settlement for Health and Social Care: Final Report whose primary recommendation was that, 'England moves to a single, ring-fenced budget for health and social care, with a single commissioner'. The King's Fund has tested stakeholder views following the Barker report and has found a, "…groundswell of support for the central proposition of a new settlement based on a single ring-fenced budget and a single local commissioner" (p.4) but significant concern as to how this can be achieved without major organisational change for which there is no appetite. To this end the King's Fund has focussed on exploring options for a single commissioning arrangement with a ring-fenced budget for health and social care.

The report sets out three potential options for integrated commissioning:

Option 1 – build on existing organisational and policy arrangements

Health and social care funding would continue to be routed separately to CCGs and local authorities with an expectation that they reach local agreement on how the funding streams should be aligned around agreed local priorities and needs, and how services should be commissioned. It would be for CCGs and the local authority to agree whether their health and wellbeing board is ready and able to take on a formal decision-making role in respect of commissioning decisions.

Option 2 – CCG or local government to take responsibility

The second option is to assign lead responsibility for commissioning either to local government or to CCGs. A clear advantage of this approach is that there would be a single and unambiguous local body with clear responsibility and accountability for the entire integrated budget.

Option 3 – a new vehicle: 'health and wellbeing boards plus'?

"A third option is to establish a completely new local vehicle to be the single commissioner. This could appear to involve the most extensive organisational change of all as it would leave no role for either local authorities or CCGs. However, there is an evolutionary option that would not involve a complete upheaval of existing organisations but which would build on them – this is to revamp the role of health and wellbeing boards" (p.41) with health and wellbeing boards becoming local executive decision-making body for the integrated budget.

Local implications and considerations

- To consider developing a shared vision and model for integrating commissioning locally and what the role of the Health and Wellbeing Board might be.

References

Barker, K. (2014) *A New Settlement for Health and Social Care: Final Report*. King's Fund, London.

Humphries, R. & Wenzel, L. (2015) *Options for Integrated Commissioning: Beyond Barker*. King's Fund, London.

7 CCGs could pick 'min' or 'max' roles under NHS England strategy

In December 2015, the Health Services Journal reported that NHS England is drafting a national commissioning strategy. The Strategy is expected to be published in 2016 and is anticipated to set out what CCGs should be responsible for as part of an "accountable care system". NHS England will set out a number of potential scenarios for the role and function of Clinical Commissioning Groups (CCGs). Two potential models are:

- A minimal model with a reduced CCG role focused on contract monitoring and challenge, actuarial functions, budget setting, setting and measuring outcomes;
- A maximal model leading service redesign, designing and monitoring multiple contracts, assessing the needs of a population, potentially over a large geographical area.

It is expected that the new models will "...redefine the boundary between commissioning and provision". The overriding commissioning strategy work also aims to establish "..."place based commissioning", bringing together commissioning of primary care and specialised services with CCGs' core general acute and community responsibilities".

NHS England is also seeking to design new kinds of outcomes based contracts including capitated budgets for accountable care organisations, and contracts for specific specialist services - supporting the development of multispecialty community providers and primary and acute care systems, which are being developed in new care model vanguard sites and could also underpin collaborations between trusts on a single specialism, as is proposed by some hospital "chain" vanguards.

The future is likely to be a 'mixed economy' of commissioning models and will also move the boundaries between provision and commissioning.

Local implications and considerations

- The health and Wellbeing Board needs to understand and support development of a preferred model for the local CCG – Southern Derbyshire CCG.
- To consider the future locally in relation to provider/ commissioner boundaries.

References

Williams, D. (2015) 'CCGs could pick 'min' or 'max' roles under NHS England strategy' in *Health Services Journal.* 1st December 2015.

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Date:	30th December 2015