DERBYSHIRE COUNTY COUNCIL

DERBYSHIRE
ADULT CARE BOARD

THURSDAY 12TH SEPTEMBER 2013
2:00PM TO 4:00PM
COMMITTEE ROOM 1, COUNTY HALL, MATLOCK, DERBYSHIRE, DE4 3AG

A G E N D A

	Time	Item	Lead	Information/ Discussion/ Decision
1	2:00pm	Welcome & Introductions		Cllr Neill
2	2:05pm	Noted Apologies:		
3	2:06pm	Minutes from the meeting held on 11th July 2013 (attached)		Information
4	2:16pm	Section 256 (attached)	J Matthews	Discussion
5	2:35pm	Lead Commissioning (attached)	I Cocking	Discussion
6	2:45pm	Integrated Care Developments (attached)	Cllr C Neill/ B Robertson	Discussion
7	3:45pm	Health & Wellbeing Board Agenda	J Matthews	Discussion
	4:00pm	**FINISH**		
		The next meeting of the Adult Care Board will take place on 14th November 2013 at 2:00pm in Committee Room 1, County Hall, Matlock.		

Pauline Innes
PA to Bill Robertson, Strategic Director - Adult Care Department
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DERBYSHIRE COUNTY COUNCIL

ADULT CARE BOARD

MINUTES OF A MEETING HELD ON THURSDAY 11TH JULY 2013 AT 2:00PM DERBYSHIRE COUNTY COUNCIL, COMMITTEE ROOM 1, MATLOCK HQ

PRESENT:

Cllr Clare Neill	CN	Derbyshire County Council Cabinet Member (Adult Care) **Chair**
Bill Robertson	BR	Derbyshire County Council – Strategic Director Adult Care
James Matthews	JM	Derbyshire County Council – Adult Care
Andrew Milroy	AMi	Derbyshire County Council – Adult Care
Dr Andrew Mott	AM	Southern Derbyshire CCG
Cllr Wayne Major	WM	Derbyshire County Council
Tony Morkane	TM	DCC - Public Health
Cllr John Lemmon	JL	South Derbyshire District Council
Helen Robinson	HR	Derbyshire Carers
Cllr Lillian Robinson	LR	North East Derbyshire District Council
L Wilmott-Shepherd	LWS	Erewash CCG
Barry Thacker	BT	Derbyshire Police
Andrew Moody	AMo	North Derbyshire CCG
Pam Wood	PW	SDCVS HRS Forums
Umar Zamman	UZ	Derbyshire Fire and Rescue

IN ATTENDANCE:

Pauline Innes	PI	Derbyshire County Council Adult Care (Minutes)
Sue Whetton	SW	Derbyshire County Council – Adult Care
Julie Vollor	JV	Derbyshire County Council – Adult Care

APOLOGIES:

Andy Layzell	Southern Derbyshire Clinical Commissioning Group
Mary McElvaney	Derbyshire County Council – Adult Care
Avi Bhatia	Erewash CCG
Bryan Bennett	Derbyshire Fire and Rescue
Russ Foster	Derbyshire Police
Andy Gregory	Hardwick CCG
Rakesh Marwaha	Erewash CCG
Jackie Pendelton	North Derbyshire CCG
Karen Ritchie	Healthwatch Derbyshire
Jo Smith	South Derbyshire CVS
Clare Watson	Tameside & Glossop PCT (CCG)
Jacqui Willis	NDVA

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Minute No	Item	Action
ACB 019/13	**WELCOME FROM CLLR NEILL AND APOLOGIES NOTED** **MINUTES FROM THE MEETING ON 7TH MARCH 2013 & MATTERS ARISING** The minutes from 7th March 2013 were noted and agreed. **MATTERS ARISING:** 011/13 – Helen Robinson informed the board that over 60 carers attended a workshop event for carers, feedback from the event would be available in due course.	**HR**
020/13	**DERBYSHIRE MENTAL HEALTH STRATEGY** • S Whetton provided a report to inform the Board of legislative, policy and commissioning developments in relation to mental health and to set out recommendations for the development of a new three year Derbyshire Adult Mental Health Strategy. • The current 'Derbyshire Vision and Strategic Direction for Adult Mental Health' was launched in 2007 and was originally planned to span ten years to 2017. However changes in structure and policies mean that it needs reviewing and updating. • The four main Derbyshire Clinical Commissioning Groups are developing localised action plans and these and the associated local consultation will support the revision of the strategy. • Engagement work to underpin the strategy development will include separate meetings with carers, service receivers, providers of health and social care services and other service providers with a role in supporting people with mental ill health including Job Centre Plus and Housing providers. • JM informed the Board that a sub group has been established to identify how to undertake the engagement and that a couple of meetings have already taken place. • The Adult Care Board noted the contents of this report and were in agreement of the recommendations for a rewrite of the Derbyshire Joint Mental Health Strategy.	**JM**
021/13	**WINTERBOURNE VIEW** • J Vollor presented the Board with an update on progress report on the implementation of the Winterbourne View	

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	Review, Recommendations and Concordat.
	• The Local Government Association and NHS England Local Stocktake was completed and submitted by the deadline of 5th July: as requested in the 31st May Gateway Letter.
	• Four work-streams have been identified, each of which has its own detailed Action Plan, and are being monitored by the Implementation Group:
	  o Work-stream 1: Development of Joint pathway for Challenging Behaviour including Transition arrangements from Child and Adolescent to Adult Services;
	  o Work-stream 2: Governance and quality monitoring and assurance programme;
	  o Work-stream 3: To focus on review of identified cohort in Out-of-Area placements;
	  o Work-stream 4: Provider operational and workforce development;
	• A transforming Care Implementation Group was established in March 2013 to ensure the Winterbourne recommendations are delivered in Derbyshire. The group meets monthly and its membership includes Public Health, the GP clinical lead for learning disability, commissioners, operational and safeguarding representatives from Derbyshire and Derby City Adult Care and Hardwick CCG.
	• Regular reporting has been established to a range of key groups including: the Learning Disability Partnership Board, Learning Disability Joint Commissioning Board, The Derbyshire Safeguarding Adults Board, the Adult Care Board and the Health and Wellbeing Board.
	• The joint assessment of individuals was completed by the end of June 2013, in line with the Department of Health requirements.
	• A learning Disability Support and Accommodation Strategy is currently under development.
	• Initial expressions of interest have been made to participate in the extension to the East Midlands 'Living Local' programme to improve local services.
	• Additional non-recurrent investment for Derbyshire and Derby City was been obtained from the Strategic Health Authority via Hardwick CCG to support the programme.
	  o Additional 12 month social work post to ensure the reviews and support planning for the people who meet Winterbourne criteria, including young people in transition, are completed;
	  o 12 month Project Manager to oversee the Winterbourne Programme
	  o Establishment and support for a new Clinical Reference
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	Group; o Audit of Advocacy Services to ensure they are fit for purpose (a review of advocacy services is part of the current commissioning programme and an initial audit of existing services has been completed). • The Adult Care Board noted this report and approved the Joint Winterbourne Strategy. • Cllr Neill passed on her thanks to JV for all the hard work that had been undertaken on the Winterbourne View Strategy to date.	**JV**
022/13	**<u>DERBYSHIRE DEMENTIA ACTION ALLIANCE</u>** • J Vollor provided the Board with a briefing about the Dementia Action Alliance and to notify the Adult Care Board of a request for Derbyshire Adult Care to join the Alliance. • The Dementia Action Alliance (DAA) represents a coming together, to date of over 480 organisations to deliver the National Dementia Declaration. • The DAA organised an initial meeting in March 2013 with a view to setting up a Derbyshire branch. This attracted a variety of public, private and independent sector services, many of which do not provide direct services to people with a dementia. • Each organisation is asked what their action plan is; the main challenges are around budget and demographic pressures. • The Adult Care Board noted this report and approved that we pursue membership of the new Derbyshire branch of the Dementia Action Alliance.	**JV**
023/13	**<u>LEAD COMMISSIONING FOR CARERS</u>** • J Vollor presented the Board with a update on progress in relation to Lead Commissioning for Carers and for People with a Learning Disability. • Detailed work is progressing on the draft Memorandum of Understanding, to ensure that an appropriate level of detail will be available for the Adult Care Board and Health and Wellbeing Board to consider the proposals in October / December 2013. Consultation will take place with Carers and other organisations. The topics being worked through in detail are those set out for Section 75 agreements that include: o Aims and Objectives. o Monitoring arrangements. o The length of the term of the agreement.	

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	o The number of agreements that will be required: to cover the main Derbyshire CCGs and for Tameside and Glossop? o Proposals for dealing with any under or over-spends in the pooled budget. o Lists of pre-existing contracts that will need to be assigned as part of the agreement. o Governance at two levels: a Board and a Management Group, with clear terms of reference needed to avoid conflicts. • Regular reporting to the Joint Carers Commissioning Group. • A checklist of actions to implement the new arrangements has been drawn up and agreed by both organisations. • Revised Terms of reference for the Joint Carers Commissioning Board. <u>People with a Learning Disability Lead Commissioning Progress to date includes:</u> • The working group with membership including commissioner representatives from Derbyshire, Derby City Adult Social Care and Hardwick CCG continues to meet monthly and report to the Learning Disability Joint Commissioning Board. • In addition, across both Lead Commissioning work streams, scoping is taking place to understand the level and type of resources that will required for Adult Care to take over the lead commissioning and associated contracting and monitoring, activities. • The Adult Care Board noted the contents of the report and the progress which has been made to date.	**JV** **JV**
024/13	**<u>MY HOME LIFE & DIGNITY CAMPAIGN</u>** • J Matthews provided the Board with recommendations about how the Age UK promoted 'My Home Life' programme may inform and support the Derbyshire Dignity Campaign. • The Derbyshire Dignity Campaign was launched in February 2011 jointly by Derbyshire Adult Care and Derbyshire NHS. It is underpinned as a set of 10 overarching principles across health and social care settings: 1. Have a zero tolerance of all forms of abuse 2. Support people with the same respect you would want for yourself or a member of your family 3. Treat each person as an individual by offering a	

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personalised service

4. Enable people to maintain the maximum possible level of independence, choice and control
5. Listen and support people to express their needs and wants
6. Respect people's right to privacy
7. Ensure people feel able to complain without fear of retribution
8. Engage with family members and carers as care partners
9. Assist people to maintain confidence and a positive self-esteem
10. Act to alleviate people's loneliness and isolation

- To date 175 teams have applied of which 123 have so far been successful in gaining the bronze award.
- On 17 May 2012 the Board gave support to proposals for a silver dignity award format. A launch has since taken place and a high level of enthusiasm was evident at an oversubscribed workshop to begin work on the silver award.
- My Home Life contributes to the dignity campaign well but its focus is restricted to care homes.
- Adult Care and 8 independent sector care home managers participated in a previous project implementing 'My Home Life' in their homes.
- A training initiative which is proceeding is titled 'Developing leadership and management in person centered dementia care to aid the reduction of inappropriate use of anti-psychotic medication', this is being facilitated by the Adult Care training section, funded by £120,083 from the former Strategic Health Authority. This project in two distinct phases seeks to embed a person centered culture of care, and offers a combination of action learning sets; 1:1 coaching and mentoring sessions and the training skills and resources Registered Managers will need to develop their staff groups and care environments. All homes taking part in the project are expected to achieve the Dignity Bronze Award. It is anticipated that approximately 40 independent sector care homes will take part in the two phases of the project.
- It is proposed additionally that Adult Care and the NHS jointly facilitate a presentation by Age UK of My Home Life which care homes might attend and be encouraged to self-fund the cost per Care Home of participation in a My Home Life initiative would be £2,500 approximately this funding would then contribute to the dignity campaign. We would invite some previous participants to attend and speak about

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	their experience. • Cllr Neill offered to contribute a venue for the presentation by Age UK. • Age UK would facilitate the day and report back to the Adult Care Board and it was further suggested that a small number attendees could provide feedback to the Board. • The Adult Care Board noted the recommendations of this report and was happy to support a stakeholder event for Age UK to encourage care home managers to undertake 'My Home Life'.	**CN** **JM**
025/13	**INTEGRATED CARE DEVELOPMENTS** • Cllr Neill provided the Board with an update on Integrated Care Developments. • Derbyshire County Council has been named as a 'Whole Person Care Innovation Council' by Andy Burnham MP, Shadow Secretary of State for Health. • At the Local Government Association conference in Manchester last week, Andy Burnham (MP) announced that six local authorities, including Derbyshire, would be working with him to test out how far health and social care services can be integrated, within existing legislation. • Meetings will take place every 6 months with other Local Government Authorities to inform and share the development on adult health and social care integration. • Cllr Neill and Cllr Dave Allen, County Council Cabinet Member for Health and Communities travelled to London to meet with Shadow Health Minister Andrew Gwynne MP to discuss the initiative in more detail. • Cllr Neill informed the Board that we should know by the end of July what the Authority share of the £8.8 billion national funding pot will be. • B Robertson informed the Board that the personalisation agenda for social care which is a national programme will continue. • No major announcements have been received around integration on Personal Health Budgets for Older People. • Discussions took place around the Spending Round: Health Settlement 2015-16, and the £3.8bn Integration Transformation Fund which will be held by local authorities. • Cllr Clare Neill requested Integration to be placed on Septembers Agenda for more in-depth discussions to take place, 1 hour session to be allocated. Existing groups will undertake an audit of current activities and investment	

	• J Matthews informed the Board that a group already is in place which oversees joint commissioning and integrated care investment and the group could be used to support the development of the response to the recent Department of Health funding initiative on integration. The voluntary and community sector will be kept up to date with the work and offered the opportunity to comment on it.	
026/13	**HEALTH & WELLBEING STRATEGY ACTION PLAN** • J Matthews provided the Board with an update for the Health & Wellbeing Strategy Action Plan.	
027/13	**DERBYSHIRE PARTNERSHIP FORUM (DPF)** • Cllr Neill provided feedback from the DPF meeting held on the 28th June 2013 concerning a presentation on Housing, Health and Social Care. • The DPF presentation centered on the importance of housing as a key support to improving outcomes for people through improved health and social care integration. • Cllr Neill has met with a number of people in the County Council to get older people's views about the importance of their homes and it has been identified that there needs to be a three pronged approach: o Independent Living o Development of Extra Care o Maintain and Develop Residential Care • The DPF had agreed to hold a stakeholder workshop about housing and this will focus on two aspects: a) Making DFG work which would involve mapping the current state and future for DFG's, ensuring that adaptations move quicker, developers and architects to be involved in processes. It is essential that there is a much leaner process whilst ensuring that we are building life time homes. The workshop to take place in October 2013 which will be action focused and also play in residential care strategy. • Cllr Wayne Major requested that we need to engage with local Housing Associations and Alms Houses. • J Matthews stated that Alms Houses would be funded through housing related support J Matthews to seek further information about Alms Houses in Derbyshire. • J Matthews informed the Board that a brown paper exercise	**JM** **JM**

	is to be undertaken on DFGs and the outputs from this exercise could be used for the planned workshop in October. J Matthews to advise Cllr Neill of the date when the brown paper exercise is to take place.	
	The next meeting of the Adult Care Board will take place on Thursday 12th September 2013 at 2:00pm in Committee Room 1, County Hall, Matlock.	

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DERBYSHIRE COUNTY COUNCIL

REPORT FOR ADULT CARE BOARD

12TH September 2013

Progress report on development of Lead Commissioning for Carers

Purpose of the Report

To provide the Board with a further update on the activities undertaken to develop lead commissioning for carers.

Background

The Board approved the report 'Adult Care and Joint Commissioning Priorities 2012 – 13', on 15th March 2012, which included the priority *'Adult Care is proposing to be the Lead Commissioner for Carers'.*

In November 2012, March 2013 and July 2013 further update Reports were presented to the Board setting out the next steps and proposed timeline. The Board noted the content of the Reports and agreed the proposed actions and timeline.

The next steps were as follows:-

- Representatives from the Council and NHS SDCCG (as lead CCG for carers) to develop a detailed project plan for agreement on the preferred option; including consultation and reporting on the preferred model through existing governance structures
- A draft Section 75 Agreement for a Pooled budget to be drawn up in order for the Adult Care Board and the Health and Wellbeing Board to consider the proposals in October/December 2013.
- To proceed to implementation of an agreed way forward for April/ May 2013

This Report is to inform the Board of a change of direction regarding the partnership arrangements.

Information and Analysis

On 8th August 2013 a joint statement on the Health and Social Care Integration Transformation Fund (ITF) was issued by the Local Government Association and NHS England.

The funding is described as 'a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities'.

The ITF comes into full effect in 2015/16.The composition of the ITF includes the NHS funding for carers breaks.

It would therefore seem prudent, in the light of carers breaks funding being part of the ITF transfer in 2015/16, to establish a Memorandum of Understanding (MOU) between the Derbyshire CCGs and Derbyshire county council , to be put in place for 2014/15. The difference in approach means that:

- Adult Care will still be the lead commissioner
- The MOU (rather than a Section 75 agreement) will be the formal agreement between the partners, but there will not be a pooled budget for carers in 2014/15.

The MOU will safeguard the spend on carers support, and establish a work plan and a work programme for the Carers Joint Commissioning Board. It will enable the reshaping of services for carers in forthcoming years.

It is intended that the Carers Joint Commissioning Board will operate as the strategic lead for planning and commissioning carers support across all Derbyshire County Council Departments and the Derbyshire CCGs.

The timescales for finalising these arrangements are set out below

Carers lead Commissioning Project Plan

Task	**Timescale**
Agree and develop required documentation for MOU	By September 2013
Clarify involvement of Tameside and Glossop CCG	September 2013
Clarify involvement of Public Health and CAYA	September 2013
Report to Directorate and CCGs	September/October 2013
Report to Adult Care Board	November 2013
Report to Health and Wellbeing Board	December 2013
Report to Cabinet	February 2014
MOU in place	April 2014
Launch Carers Lead Commissioning Board	April 2014

OFFICERS RECOMMENDATIONS

1) The Adult Care Board is asked to note the contents of this report, support the change in direction to an MOU, and the progress which has been made to date.
2) A further progress report will be presented to the Adult Care Board at its November meeting.

Iseult Cocking

Commissioning Service Manager

HM Government

To: Local authority chief executives

Directors of Adult Social Services

Chairs of Health and Wellbeing Boards

9th August, 2013

The care and support Spending Round settlement

Dear colleagues,

This has been a significant summer for the care and support sector. Not only have we launched the consultation on the implementation of care and support funding reform, we have announced the settlement of the Spending Round for 2015-16. You may have already heard a lot about the Spending Round but we are writing to you to set out exactly what it means for the social care sector.

You will also have seen the joint statement from NHS England and the Local Government Association setting out details of the Integration Transformation Fund. While this letter will inevitably cover some of the same ground, we hope to be able to put this element of the Spending Round settlement in the wider context of the overall settlement for local government and our programme of reforms for care and support.

Integration Transformation Fund

Firstly, we have announced that we are creating a £3.8bn pooled budget in 2015/16. We have been clear that we need to move more care out of hospitals and into the community, so that we can intervene earlier to prevent people from reaching crisis points. We need much better integration between health and social care, so that care is centred around the person rather than the service, and to reduce the amount of money that is wasted when services do not work together effectively. To help enable this, we will create pooled budgets for health and social care.

The composition of the Integration Transformation Fund

The Integration Transformation Fund will consist of a combination of new and existing funding streams. Some of the existing funding is for particular provision, such as that for carers breaks and reablement. We expect these responsibilities and services to continue, with local authorities and CCGs working together more closely to improve the delivery of these.

£1.9bn of <u>existing funding</u> that will already be allocated across the health and social care system to support integration in 2014/15

<u>£1.53bn revenue funding</u>

- **£1.1bn – continuation of the 2014/15 NHS transfer.** Over the course of the 2010 Spending Review period, the NHS has transferred money to support care and support with a health benefit. Previously, it was intended that this would amount to £900m in 2014/15 – this Spending Round has announced a further £200m to help local authorities prepare for the implementation of the Integration Transformation Fund and make early progress on priorities. In 2015/16, this £1.1bn will be put into the pooled budgets.
- **£300m – reablement funding.** Reablement funding is currently identified within CCG allocations. In 2015/16, this money will be placed within the pooled budgets.
- **£130m – Carers break funding.** Funding for carers breaks is provided by the NHS. This money will form a part of the pooled budget.

<u>£354m capital funding</u>

- **£134m – Community Capacity Grant.** The Department of Health's capital grant for care and support will form a part of the pooled budget in 2015/16. Of this, £50m is to fund the changes in IT systems necessary for integration and funding reform.
- **c.£220m – Disabled Facilities Grant.** This will be put into the pooled budget. More work needs to be done on how this will work in practice, given that this is currently also allocated to lower tier councils.

£1.9bn <u>additional</u> NHS funding

- In addition to the existing funding streams outlined above, the NHS will contribute a further £1.9bn to the Integration Transformation Fund.

Conditions on the Integration Transformation Fund

To access this funding, all areas will need to produce local plans for how the money will be used across health and social care, signed off by the NHS and local authorities, and with a strong role for Health and Wellbeing Boards in the oversight of these. These plans must demonstrate that care and support services will be protected. Plans must also include:

- 7-day working in health and social care, to stop people from being stuck in hospital over the weekend;
- better data sharing, including universal use of the NHS number as a unique identifier;
- a joint approach to assessment and care planning;
- implications for acute service redesign;
- support for accountable lead professionals in respect of joint care packages; and
- arrangements for redeploying funding that is held back in the event that outcomes are not fully delivered.

£1bn of the funding in the pooled budgets will be linked to outcomes achieved, based on a combination of locally and nationally set outcome measures. Half of the funding will be paid at the beginning of 2015-16 (based on performance in the previous year) and the remainder paid in the second half of the year against performance in year. In order to access all of this funding, local areas will need to meet their planned outcomes.

We will be working closely with the NHS and local government over the summer to finalise the details of how this scheme will work. The joint statement that you have received from NHS England and the Local Government Association contains more details on timescales and what you should be thinking about now.

Social care funding reform

As you will know, we are currently consulting on funding reform for care and support. From April 2015, there will be a universal requirement for local authorities to offer deferred payment agreements to care users who meet certain criteria; and although the cap on care costs does not come into force until April 2016, local authorities will face transitional costs in 2015/16.

Through the Department for Communities and Local Government, we will be providing a **£285m revenue grant** to local authorities to cover these costs in 2015/16. Of this, £110m is to cover the cost of deferred payments, and the other £175m to cover the capacity building and early assessments required for transition to the capped cost model.

Along with the £50m capital funding provided for information systems in the Integration Transformation Fund, this means a total of £335m will be provided for funding reform in 2015/16.

Other costs arising from the Care Bill

There are a number of other policies that we are implementing through the Care Bill that will lead to costs for local authorities, including new duties for the assessment and support of carers, better provision of information and advice, and a national minimum eligibility threshold. The Department of Health published impact assessments for these policies in 2012, and the total cost to local authorities in 2015/16 is estimated to be £108m.

In line with the Government's policy on funding new burdens on local authorities, we have ensured that the Spending Round settlement funds these costs in full, through the local government settlement and the Integration Transformation Fund.

The Independent Living Fund

From April 2015, the Independent Living Fund will close, and local authorities will take on full responsibility for meeting the needs of Independent Living Fund users.

The Government has always been clear that the closure of the Independent Living Fund is not about saving money, but about rationalising the system and treating all people with care and support

needs consistently. Local authorities will need to take decisions about on-going care for Independent Living Fund users on a case-by-case basis, but we believe that local authorities need to be funded to continue with existing care arrangements for these people where they judge that this is appropriate.

To provide the necessary resources for councils to do this, we will be paying a **£188m grant** in 2015/16 to local authorities through the Department for Communities and Local Government. The size of this grant is based on projections of what the Independent Living Fund would have spent had it remained open.

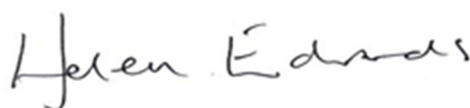
The wider local government settlement

The settlement for local government overall included a 10% reduction in LGDEL (which includes the local share of business rates), with an overall reduction to local government spending anticipated at around 2.3%.

In order to continue to deliver high quality services within this settlement, councils – including adult social care departments – will need to continue their good work in achieving efficiency savings. If we can continue to deliver on efficiency, then the Integration Transformation Fund and the wider local government settlement provide sufficient funding for councils to protect care and support services in 2015/16.

We are committed to continuing to work with you and your colleagues to ensure these changes deliver real benefits to some of the most vulnerable groups in our communities.

Yours sincerely,



JON ROUSE

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NHS England

HOW CAN WE IMPROVE THE QUALITY OF NHS CARE?

HOW CAN WE MEET EVERYONE'S HEALTHCARE NEEDS?

HOW CAN WE MAINTAIN FINANCIAL SUSTAINABILITY?

WHAT MUST WE DO TO BUILD AN EXCELLENT NHS NOW & FOR FUTURE GENERATIONS?

The NHS belongs to the people

A CALL TO ACTION

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Foreword: NHS Call to Action

The NHS is 65 this year: a time to celebrate, but also to reflect. Every day the NHS helps people stay healthy, recover from illness and live independent and fulfilling lives. It is far more than just a public service; the NHS has come to embody values of fairness compassion and equality. The NHS is fortunate in having a budget that has been protected in recent times, but even protecting the budget will not address the financial challenges that lie ahead.

If the NHS is to survive another 65 years, it must change. We know there is too much unwarranted variation in the quality of care across the country. We know that at times the NHS fails to live up to the high expectations we have of it. We must urgently address these failures, raise performance across the board, and ensure we always deliver a safe, high quality, value-for-money service. We must place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness. We also need to do far more to help those with mental illness.

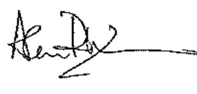
There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS. Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health and care services.

This is not about unnecessary structural change; it is about finding ways of doing things differently: harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more heath and care services; and much more besides. It's about changing the physiology of the NHS, not its anatomy.

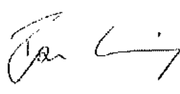
For these reasons, this new approach cannot be developed by any organisation standing alone and we are committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre, the Local Government Association, the NHS Commissioning Assembly, Health Education England, the Care Quality Commission (CQC) and NHS England want to work together alongside patients, the public and other stakeholders to improve standards, outcomes and value.

We are all committed to preserving the values that underpin the NHS and we know this new future cannot be developed from the top down. A national vision that will deliver change will be realised locally by clinical commissioning groups, Health & Wellbeing Boards and other partners working with patients and the public. That is why we are supporting a national 'Call to Action' that will engage staff, stakeholders and most importantly patients and the public in the process of designing a renewed, revitalised NHS. This is all about neighbourhoods and communities saying what they need from their NHS; it is about individuals and families saying what they want from their NHS. Above all, this is about ensuring the NHS serves current and future generations as well as it has served those in the past.

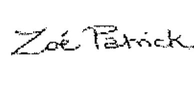
David Behan,
Chief Executive
Care Quality Commission



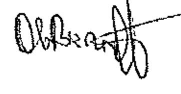
Alan Perkins,
Chief Executive
Health and Social Care Information Centre



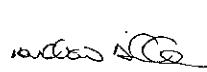
Ian Cumming,
Chief Executive
Health Education England



Zoe Patrick,
Chair of the LGA Community Wellbeing Board
Local Government Association

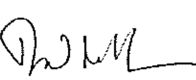


David Bennett,
Chief Executive
Monitor



Andrew Dillon,
Chief Executive
National Institute for Health and Care Excellence

Peter Melton,
Chief Clinical Officer, North East Lincolnshire CCG, Co-chair of NHS Commissioning Assembly steering group



David Nicholson,
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NHS England

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Chief Executive
NHS Trust Development Authority

Duncan Selbie,
Chief Executive
Public Health England

The NHS belongs to the people: a call to action

Executive Summary

Every day the NHS saves lives and helps people stay well. It is easy to forget that only 65 years ago many people faced choosing between poverty if they fell seriously ill or forgoing care altogether. Over the decades since its inception the improvements in diagnosis and treatment that have occurred in the NHS have been nothing short of remarkable. The NHS is more than a system; it is an expression of British values of fairness, solidarity and compassion.

However, the United Kingdom still lags behind internationally in some important areas, such as cancer survival rates.[1] There is still too much unwarranted variation in care across the country, exacerbating health inequalities.[2] As the Mid-Staffordshire and Winterbourne View tragedies demonstrated, in some places the NHS is badly letting patients down and this must urgently be put right.

But improving the current system will not be enough. Future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.

The NHS has already implemented changes to make savings and improve productivity. The service is on track to find £20 billion of efficiency savings by 2015. But these alone are not enough to meet the challenges ahead. Without bold and transformative change to how services are delivered, a high quality yet free at

[1] Christopher Murray et al. (March 2013), "UK health performance: findings of the Global Burden of Disease Study 2010", The Lancet.
[2] For example, unwarranted variation in common procedures and in expenditure. See John Appleby et al. (2011), "Variations in health care: the good, the bad and the inexplicable", King's Fund and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

In order to preserve the values that underpin it, the NHS must change to survive. Change does not mean top-down reorganisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future. There are opportunities to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals. These include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. To do so, the NHS must harness new, transformational technology and exploit the potential of transparent data as other industries have. We must be ready and able to share these data and analyses with the public and to work together with them to design and make the changes that meet their ambitions for the NHS.

So this document is a 'Call to Action' – a call to those who own the NHS, to all who use and depend on the NHS, and to all who work for and with it. Building a common understanding of the challenges ahead will be vital in order to find sustainable solutions for the future. NHS England, working with its partners, will shortly launch a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give a voice to all who care about the future of our National Health Service. This programme will be the broadest, deepest and most meaningful public discussion that we have ever undertaken.

Bold ideas are needed, but there are some options we will not consider. First, doing nothing is not an option – the NHS cannot meet future challenges without change. Second, NHS funding is unlikely to increase; it would be unrealistic to expect anything more than flat funding (adjusted for inflation) in the coming years. Third, we will not contemplate cutting or charging for core NHS services – NHS England is governed by the NHS Constitution which rightly protects the principles of a comprehensive service providing high quality healthcare, free at the point of need for everyone.

The Call to Action will not stifle the work that clinical commissioning groups and their partners have already accomplished. It is intended to complement this work and lead to five-year commissioning plans owned by each CCG. The Call to Action will also shape the national vision, identifying what NHS England should do to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels.

The NHS belongs to all of us. This Call to Action is the opportunity for everyone who uses or works in the NHS to have their say on its future.

"DOING NOTHING IS NOT AN OPTION – THE NHS CANNOT MEET FUTURE CHALLENGES WITHOUT CHANGE."

How is the NHS currently performing?

Quality at the core

Over recent years, the quality of NHS services has improved and, as a result, so has the nation's health. However, there is still too much unwarranted variation across the country. In England the Government measures the quality of care in five areas, collected together in the NHS Outcomes Framework. Each of these areas is discussed below.

Preventing people from dying early

As a nation we are living longer than ever before. Between 1990 and 2010, life expectancy in England increased by 4.2 years.[3] The NHS has made significant improvements in reducing premature deaths from heart and circulatory diseases but the UK is still not performing as well as other European countries for other conditions.[4]

Preventing disease in the first place would significantly reduce premature death rates. Early diagnosis and appropriate treatment of disease can also reduce premature deaths.

Around 80% of deaths from the major diseases, such as cancer, are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet.[5]

[3] Office for National Statistics (2011) http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-227587
[4] World Health Organisation (2013) http://data.euro.who.int/hfadb/
[5] World Health Organisation (2011) "Global Status Report on Non-communicable Diseases"

Enhanced quality of life for people with long-term conditions

Long-term conditions (LTC) or chronic diseases cannot currently be cured, but can be controlled or managed by medication, treatment and/or lifestyle changes. Examples of long-term conditions include high blood pressure, depression, dementia and arthritis.

Over 15 million people in England have an LTC. They make up a quarter of the population yet they use a disproportionate amount of NHS resources: 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England.[6] People living at higher levels of deprivation are more likely to live with a debilitating condition, more likely to live with more than one condition, and for more of their lives.[7]

The NHS, working with local authorities and the new health and wellbeing boards, needs to be much better at providing a service that appropriately supports these patients' needs and helps them to manage their own conditions. Better management of their own conditions by patients themselves will mean fewer hospital visits and lower costs to the NHS overall, and more community-based care, including care delivered in people's homes

"BETTER MANAGEMENT BY PATIENTS WILL MEAN FEWER HOSPITAL VISITS & LOWER COSTS TO THE NHS OVERALL."

Helping people recover following episodes of ill health or following illness

Demand on NHS hospital resources has increased dramatically over the past 10 years: a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75.[8] A combination of factors, such as an ageing population, out-dated management of long term conditions, and poorly joined-up care between adult social care, community services and hospitals accounts for this increase in demand.

Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year.[9]

New thinking about how to provide integrated services in the future is needed in order to give individuals the care and support they require in the most efficient and appropriate care settings, across health and social care, and in a safe timescale. For example, the limited availability of some hospital services at weekends has a negative impact on all five domains of the NHS Outcomes Framework: preventing people from dying prematurely; enhancing the quality of life for people with long-term conditions; helping people to recover from ill health and injury; ensuring people have a positive experience of care; and caring for people in a safe environment and protecting them from avoidable harm.

[6] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).
[7] The Marmot Review (2010), "Fair Society Healthy Lives".
[8] Royal College of Physicians (2012), "Hospitals on the edge? The time for action".
[9] Health and Social Care Information Centre http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care+-+England%22&area=&size=10&sort=Relevance]

This is why the first offer in *Everyone Counts: Planning for Patients*, is to support the NHS in moving towards more routine services being available seven days a week. The National Medical Director has established a forum to identify how to improve access to more comprehensive services seven days a week which will report in the autumn of 2013.

NHS England recently announced a review of urgent and emergency services in England, which will also recommend ways to meet the objective of a seven-days-a-week service. Not only will this offer improved convenience for patients, full-week services will also improve quality and safety.

Patient experience

The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study[10] of eleven leading health services reported that 88% of patients in the UK described the quality of care they had received in the last year as excellent or very good, ranking the UK as the best performing country. However, the data also show that the UK has improvements to make in the coordination of care and patient-centred care.

Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS. People from disadvantaged groups including the frail older population, some black and minority ethnic groups, younger people and vulnerable children, generally access poorer quality services and have a poorer experience of care (some also have lower life expectancies). This can be made worse by these groups having lower expectations of the experience of care and being less likely to seek redress. We must act to improve access and the quality of services for these less advantaged groups.

"EVERYONE WORKING IN THE NHS MUST STRIVE TO MAINTAIN AND IMPROVE ON THIS HIGH LEVEL OF PATIENT SATISFACTION AND EXTEND IT TO EVERYONE WHO USES THE NHS."

[10] Commonwealth Fund (2011), "International Health Policy Survey".

Patient safety

Although great improvements in patient safety have been made, the findings from the Mid-Staffordshire public inquiry set out starkly what can happen when safety is not at the heart of everything the NHS does. The NHS must work to ensure that all patients experience the safe treatment they deserve. Global healthcare expert Professor Don Berwick was recently asked by the Prime Minister to look into improving safety in the NHS and will report back with his findings later this year.

In addition to reducing harmful events, we must make it easier for staff to report incidents. In 2011, 1,325,360 patient safety incidents were reported to the National Reporting and Learning System,[12] of which 10,916 or less than 1% were serious. Despite this large number of reports we know we have not captured everything, and are working to make it easier for staff and patients to report incidents or near-misses. Learning from even largely minor incidents is important as it helps the NHS to avoid more serious incidents in the future.

Over the past 15 years, international studies have suggested that around 9 in 10 patients admitted to hospital experience safe treatment without any adverse events and our NHS is no different. But even these relatively low levels of adverse events are far too high. Of those people who do experience adverse events a third of them experienced greater disability or death.[11]

Health inequalities

Health inequalities is the term that describes the unjust differences in health, illness and life expectancy experienced by people from different groups of society. In England, as elsewhere, there is a so-called 'social gradient' in health: the more socially deprived people are, the higher their chance of premature mortality, even though this mortality is also more avoidable. People living in the poorest areas of England and Wales, will, on average, die seven years earlier than people living in the richest areas.[13] The average difference in disability-free life expectancy is even worse: fully 17 years between the richest and poorest neighbourhoods.[14] Health inequalities stem from more than differences in just income - education, geography, and gender can all play a role.

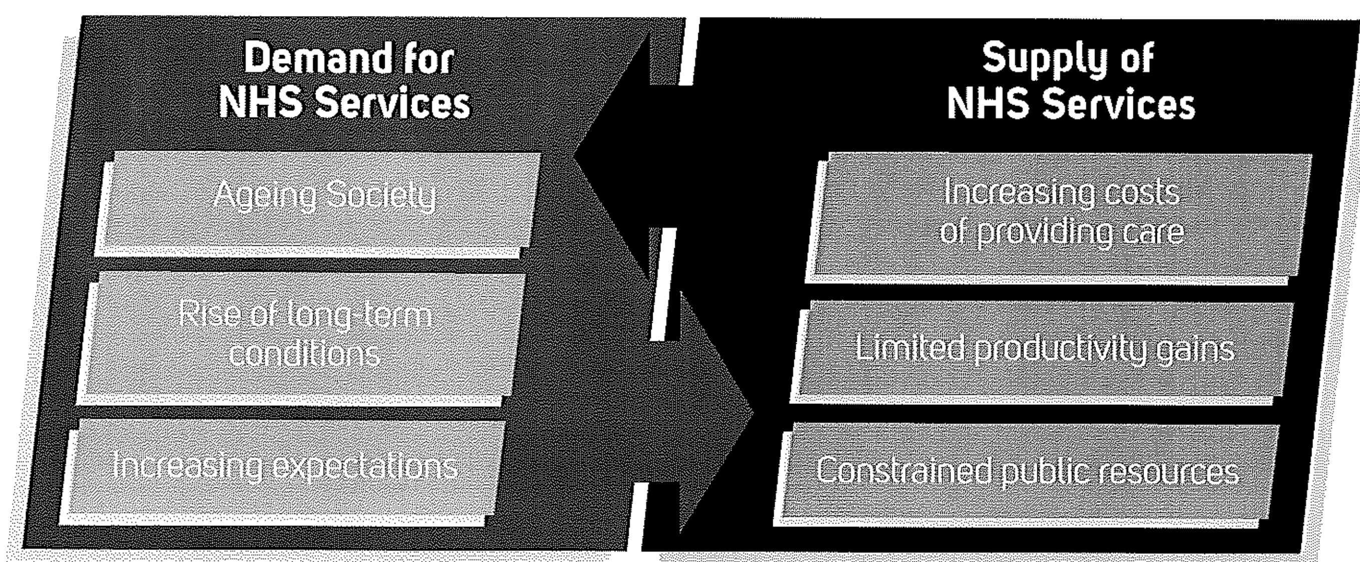
The NHS cannot address all the inequalities in health alone. Factors such as housing, income, educational attainment and access to green space are also important (the "wider social determinants of health"). In fact, it is estimated that only 15-20% of inequalities in mortality rates can be directly influenced by health interventions that prevent or reduce risk. If the NHS is to help tackle these inequalities we must work closely with Government departments, Public Health England, local authorities and other local partners to ensure the effective coordination of healthcare, social care and public health services.

[11] Charles Vincent, Graham Neale and Maria Woloshynowych (2001) "Adverse events in British hospitals: preliminary retrospective record review", British Medical Journal.
[12] National Patient Safety Agency (2012), "National Reporting and Learning System Quarterly Data Workbook" http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=135153
[13] The Marmot Review (2010), "Fair Society Healthy Lives"
[14] The Marmot Review (2010), "Fair Society Healthy Lives"

What challenges will the health and care service face in the future?

As the NHS strives to improve the quality and performance of current NHS services and to live up to the high expectations of patients and the public, we must anticipate the challenges of the future - trends that threaten the sustainability of a high-quality health service, free at the point of use. It is the potential impact of these trends that means that while a new approach is urgently needed, we must take a longer-term view when developing it.

Future pressures on the health service

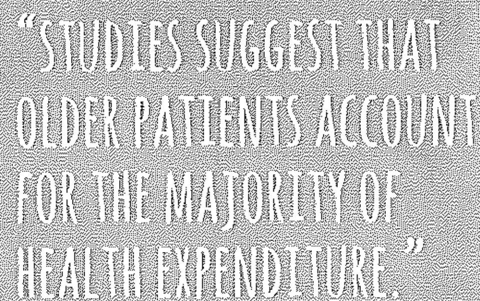


Ageing society

People are living longer and while this is good news an ageing population also presents a number of serious challenges for the health and social care system:

- Nearly two-thirds of people admitted to hospital are over 65 years old.
- There are more than 2 million unplanned admissions per year for people over 65, accounting for nearly 70% of hospital emergency bed days.[15]
- When they are admitted to hospital, older people stay longer and are more likely to be readmitted.[16]
- Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older - the most intensive users of health and social care.[17]

Studies suggest that older patients account for the majority of health expenditure. One analysis found that health and care expenditure on people over 75 was 13-times greater than on the rest of the adult population.[18]



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Extra care housing: supporting older people to stay independent

Extra care housing is sometimes referred to as very sheltered housing or housing with care. It is social or private housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home.

This 'retirement village' type of housing offers an alternative to traditional nursing homes, providing a range of community and care services on site. Compared with residence in institutional settings, extra care housing is associated with better quality of life and lower levels of hospitalisation, suggesting the potential for overall cost savings.[19]

[15] Candice Imison et al. (2011), "Older people and emergency bed use: exploring variation", King's Fund.
[16] Jocelyn Cornwell et al. (2012), "Continuity of care for older hospital patients: A call for action", King's Fund.
[17] Commission on Funding of Care and Support (2011), "Fairer Care Funding: The Report of the Commission on Funding of Care and Support".
[18] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[19] A Netten et al. (2011), "Improving housing with care choices for older people: an evaluation of extra care housing", Personal Social Services Research Unit.

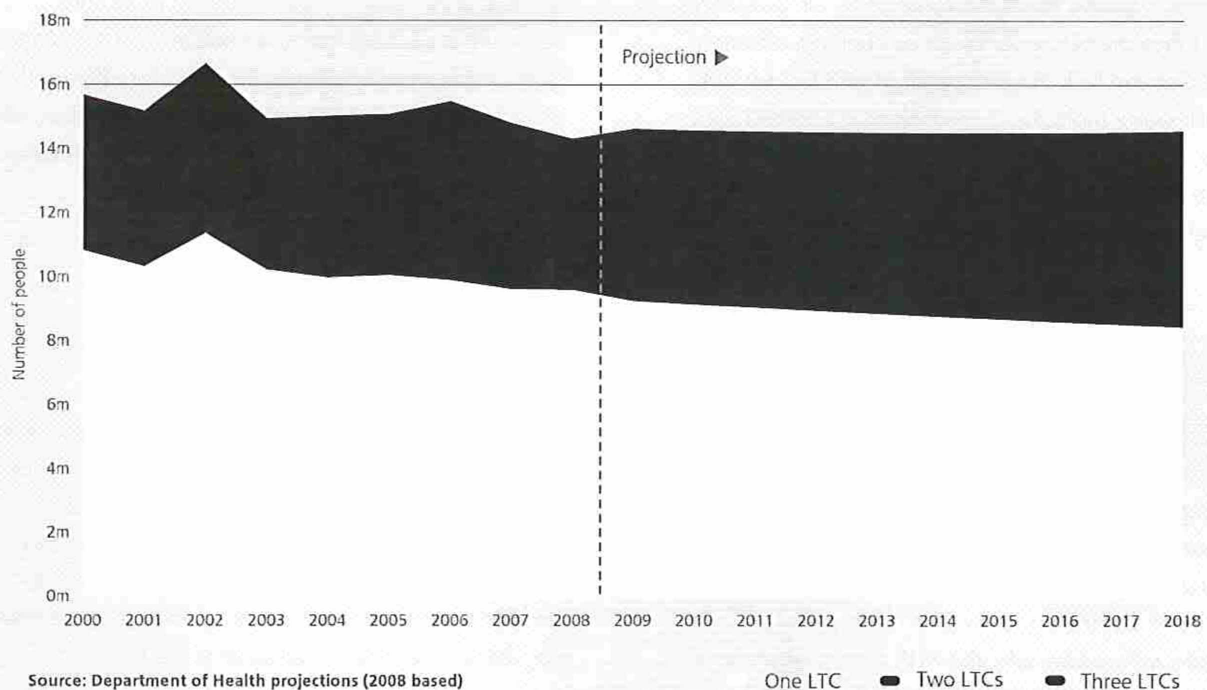
Changing burden of disease

People with one or more long-term conditions are already the most important source of demand for NHS services: the 30% who have one or more of these conditions account for £7 out of every £10 spent on health and care in England. Those with more than one long-term condition have the greatest needs and absorb more healthcare resources; for example, patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. These multi-morbid, high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018.[20]

Patients with multiple long-term conditions must be managed differently. A hospital-centred delivery system made sense for the diseases of the 20th century, but today patients could be providing much more of their own care, facilitated by technology, and supported by a range of professionals including clinicians, dieticians, pharmacists and lifestyle coaches. They also need close coordination amongst these different professionals.

> "THE 30% WHO HAVE ONE OR MORE LONG-TERM CONDITION ACCOUNT FOR £7 OUT OF EVERY £10 SPENT ON HEALTH AND CARE IN ENGLAND"

Actual/projected numbers with one or more long-term conditions by year and number of conditions



Source: Department of Health projections (2008 based)

[20] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).

Meeting the dementia challenge: rapid diagnosis and referral

There are now 800,000 people living with dementia in the UK. By 2021, the number of sufferers is projected to exceed one million and dementia is estimated to cost the NHS, local authorities and families £23 billion a year. As the Prime Minister's 2012 Challenge on Dementia noted, diagnosis comes too late for many dementia patients and they and their families don't always get the care and support they need. This is in part because too little is known about the causes of this disease and how to prevent it, but some areas are leading the way in offering better care. In Stockport, Greater Manchester, local GPs are working with the Alzheimer's Society to increase diagnosis rates and provide post-diagnosis support. GPs have agreed a 'fast-track' referral process for suspected dementia patients that will also trigger support from Alzheimer's Society staff and volunteers. The scheme also sets out to improve the skills of clinicians to better recognise the early signs of dementia and increase early detection.[21]

Lifestyle risk factors in the young

We know that the risk of developing debilitating diseases is greatly increased by personal circumstances and unhealthy behaviours such as drinking, smoking, poor diet and lack of exercise, all of which contribute to premature mortality. If predictions are correct, and 46% of men and 40% of women are obese by 2035, the result is likely to be 550,000 additional cases of diabetes, and 400,000 additional cases of stroke and heart disease.[22] Although we understand the problem, we do not yet have enough evidence to be sure about what will facilitate sustainable weight loss and other associated behaviours. Working together with individuals, their families, employers and communities to develop effective approaches will be an extremely important task for the next generation NHS.

Rising expectations

Patients and the public rightly have high expectations for the standards of care they receive - increasingly demanding access to the latest therapies, more information and more involvement in decisions about their care.[23] If the convenience and quality of NHS services is compared to those in other sectors, many people will wonder why the NHS cannot offer more services online or enable patients to receive more information on their mobile telephones. Patients want seven-day access to primary care provided near their homes, places of work, or even their local shop or pharmacy. They also want co-ordinated health and social care services, tailored to their own needs. To provide this level of convenience and access, we need to rethink where and how services are provided.

[21] Alzheimer's Society (2012), "Dementia 2012".
[22] Y.C. Wang et al (August 2011), "Health and economic burden of the projected obesity trends in the USA and the UK," The Lancet.
[23] See for example Economist Intelligence Unit (2009), "Fixing Healthcare: The Professionals Perspective".

Increasing costs

The cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures than could ever have been envisaged at its inception. New drugs, technologies and therapies have made a major contribution to curing disease and extending the length and quality of people's lives. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable. It is of course a good thing that the NHS has more therapies at its disposal and can now diagnose and treat previously neglected illnesses. However, many healthcare innovations are more expensive than the old technologies they replace - for example, the latest cancer therapies[24] - which raises affordability questions. We must ensure that we invest in the technology and drugs that demonstrate the best value and this rigour must be extended throughout the system, evaluating not just therapies and technologies, but also different models of delivering health and care services.

Limited financial resources

The NHS is facing these challenges at the same time that the UK is experiencing the most challenging economic crisis since the 1930s and adjusting to an era of much tighter public finances. The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth.

Since it began in 1948, the share of national income that the NHS receives has more than doubled, an average rise of about 4% a year in real terms. As part of its deficit reduction programme the Government has severely constrained funding growth.

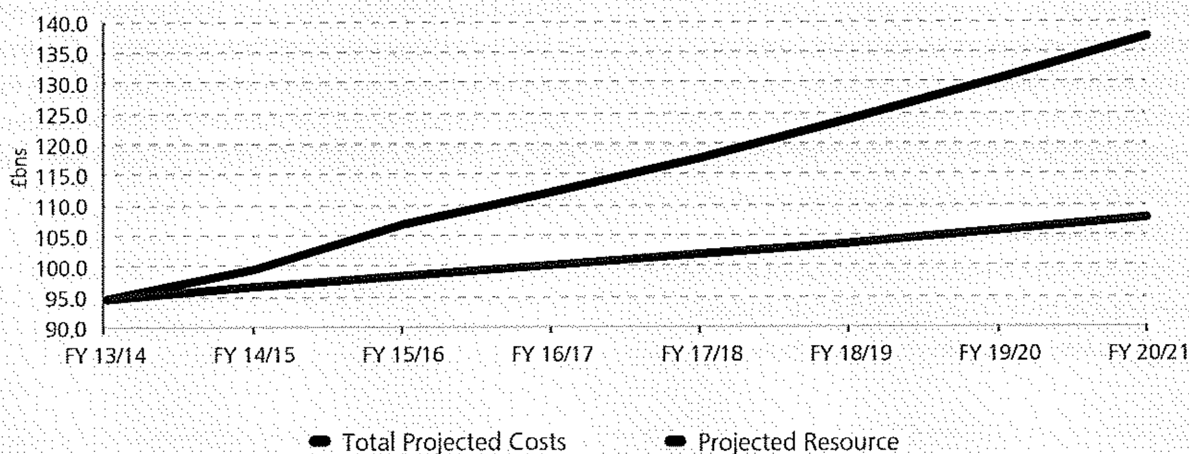
In addition, recent spending settlements for local government have not kept pace with demand for social care services. Unlike healthcare funding, social care funding is not ring-fenced; councils decide how much of their budget to spend on services based on local need. As a result, financially challenged local authorities have, in some locations, reduced spend on social care to shore up their finances. Reduced social care funding can drive up demand for health services, with cost implications for the NHS.[26] We therefore need to consider how health and care spending is best allocated in the round rather than separately in order to provide integrated services.

In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.[25]

[24] Richard Sullivan et al (September 2011), "Delivering affordable cancer care in high-income countries", The Lancet Oncology.

[25] NHS England analysis.

[26] Research has found that spending on social care could generate savings in both primary and secondary healthcare and that increased social care provision is related to reductions in delayed hospital discharges and readmission rates. See Richard Humphries (2011), "Social Care Funding and the NHS: An Impending Crisis?," King's Fund and J Forder and JL Fernández (2010), "The Impact of a Tightening Fiscal Situation on Social Care for Older People", PSSRU Discussion Paper 2723, London, Kent and Manchester, Personal Social Services Research Unit.



Source: NHS England

Limited productivity improvements

Measuring the productivity[27] of the NHS is methodologically difficult and hotly debated. The Office of National Statistics suggests that between 1995 and 2010 average productivity in the NHS grew at 0.4%, whilst in the economy as a whole it grew at a much faster rate of 2% over the same period.[28] Beneath this, NHS labour productivity levels have increased faster than equivalent rates in the wider economy by an average of 2.5% per year between 2007 and 2010.[29] This suggests that the NHS may not be using its capacity as efficiently as it could.

"THE OVERALL EFFICIENCY CHALLENGE COULD BE AS HIGH AS 5-6% IN 2015/16 COMPARED TO THE CURRENT 4% REQUIRED EFFICIENCY IN 2013/14."

NHS productivity remains an unresolved debate. However, traditional productivity improvements will not be enough to plug the future funding gap. NHS England's analysis suggests that the overall efficiency challenge could be as high as 5-6% in 2015/16 compared to the current 4% required efficiency in 2013/14.[30] Improvements such as better performance management, reducing length of stay, wage freezes or better procurement practices all have a role to play in keeping health spending at affordable levels. However, these measures have been employed to deliver the so-called "Nicholson Challenge" of 4% productivity improvements each year, amounting to some £20bn in savings, and there is a limit to how much more can be achieved without damaging quality or safety. A fundamentally more productive health service is now needed, one capable of meeting modern health needs with broadly the same resources.

[27] At its most basic productivity is the rate at which inputs (like labour, capital and supplies), are converted into outputs (like consultations or operations) and outcomes (such as good health) in order to improve quality of life.

[28] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[29] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[30] This is the challenge for the NHS after national action to constrain wages and other input costs. In recent years these have typically delivered c.1% per annum in savings which over the period modelled would equate to c.£8bn.

Seizing future opportunities

The future doesn't just pose challenges, it also presents opportunities. Technological, social and other innovations – many of which are already at work in other industries or sectors – can and should be harnessed to transform the NHS. These exciting opportunities have the potential to deliver better patient care more efficiently to achieve the transformation that is required, some of which are discussed below. These are not exhaustive and it is crucial that as a service we become better able to spot other trends and innovations with the potential to reshape health services.

A health service, not just an illness service

We must get better at preventing disease. In the future this means working increasingly closely with partners such as Public Health England, health and wellbeing boards and local authorities to identify effective ways of influencing people's behaviours and encouraging healthier lifestyles. The NHS has helped many people quit smoking (although there are still about 8m smokers in England), but has yet to develop similarly sophisticated methods for assisting people to improve their diet, take more exercise or drink less alcohol.

About 4% of the total health budget in England is spent on prevention and public health, which is above the Organisation for Economic Co-operation and Development (OECD) average,[31] but this will strike many as too little. We need to look at our health spending and how investment in prevention may be scaled up over time. It is not just about investment; partnering with Public Health England, working with health and wellbeing boards and local authorities and refocusing the NHS workforce on prevention will shape a service that is better prepared to support individuals in primary and community care settings.

[31] Department of Health (2009), "Public Health and Prevention Expenditure in England".

Giving patients greater control over their health

Developing effective preventative approaches means helping people take more control of their own health, particularly the 15 million people with long-term conditions. The evidence shows that support for self-management, personalised care planning and shared decision making are highly effective ways that the health system can give patients greater control of their health. When patients are involved in managing and deciding about their own care and treatment, they have better outcomes, are less likely to be hospitalised,[32] follow appropriate drug treatments[33] and avoid over-treatment.[34] Personalised care planning is also highly effective.[35] A major trial of Personal Health Budgets, a tool for personalised care planning, has shown improved quality of life and cost-effectiveness, particularly for higher needs patients and mental health service users.[36]

Manchester Royal Infirmary: home dialysis

Manchester Royal Infirmary has developed an innovative dialysis provision pathway, which allows patients to perform extended haemodialysis at home, rather than in hospital. This has delivered improved health and longevity, empowering patients through greater involvement, freedom and flexibility, and offers wider benefits of fewer medications and hospital visits resulting in substantial reductions in healthcare costs.[37]

Harnessing transformational technologies

The digital revolution can give patients control over their own care. Patients should have the same level of access, information and control over their healthcare matters as they do in the rest of their lives. The NHS must learn from the way online services help people to take control over other important parts of their lives, whether financial or social, such as online banking or travel services. First introduced to the UK in 1998, now more than 55% of internet users use online banking services.[38] A comparable model in health would offer online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians. Some of the best international providers already do this.[39] This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves the public.

[32] JH Hibbard and J Green (February 2013), "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs," Health Affairs.
[33] Expert Patients Programme (2010), "Self-care reduces costs and improves health: the evidence".
[34] D Stacey et al. (May 2011), "Decision aids to help people who are facing health treatment or screening decisions", Cochrane Summaries and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".
[35] "RCGP Clinical Innovation and Research Centre (2011), "Care Planning: improving the lives of people with long term conditions".
[36] https://www.phbe.org.uk/
[37] NHS England (2013), "Catalogue of Potential Innovation".
[38] Office for National Statistics (2009), "e-society" (Social Trends 41).
[39] For example Kaiser Permanente and the Veterans Administration, both in the USA

e-Intensive Care: a second pair of eyes

Guy's and St Thomas' NHS Foundation Trust, in London, has recently deployed a new e-Intensive Care Unit (ICU) to keep a 'second pair of eyes' on critically ill patients. Used in about 300 hospitals in the US, where studies have shown the system has reduced mortality rates and hospital stays, the eICU allows critical care specialists to remotely monitor patients using high-definition cameras, two-way audio and other instruments that keep track of vital signs. Not only does the system facilitate provision of 24/7 care, it also enables the most experienced specialists to spread their skills more widely and to help more patients with the greatest need.[40]

"THE NEW FRIENDS AND FAMILY TEST ASKS PATIENTS WHETHER THEY WOULD RECOMMEND THEIR HOSPITAL TO THEIR FRIENDS & FAMILY AND THE FIRST RESULTS WILL BE PUBLISHED ON NHS CHOICES IN JULY 2013"

Digital inclusion will have a direct impact on the health of the nation, and so innovation must be accessible to all, not just the fortunate. From April 2013, 50 existing UK online centres in local settings, such as libraries, community centres, cafes and pubs, are receiving additional funding to develop as digital health hubs where people will be able to find support to go online for the first time and use technology and information services such as NHS Choices to improve their health and wellbeing.

Exploiting the potential of transparent data

To support active patients the best quality data must be collected and made available. Dramatic improvements need to be made in the supply of timely and accurate information to citizens, clinicians and commissioners. Commissioners can use improved data to better understand how effectively money is being invested. For patients, more and better data will enable them to make informed decisions about their health and healthcare.

The new Friends and Family Test asks patients whether they would recommend their hospital wards or A&E department to their friends and family should they need similar care or treatment. Beginning in July 2013, the results will be published on the NHS Choices website. This is just one example of transparency which will for the first time allow citizens to compare NHS performance based on the opinions of the patients.

[40] Guy's and St. Thomas' NHS Foundation Trust, www.guysandstthomas.nhs.uk/news-and-events/2013-news/20130703-eICU.aspx

Moving away from a 'one-size fits all' model of care

A relatively small minority of patients accounts for a high proportion of health service utilisation and expenditure. This suggests an opportunity to manage patients, and help them manage themselves, more intelligently, based on an understanding of individual risk.

Healthcare is becoming more personal in other ways too. Recent biomedical advances suggest a revolution in medicine itself may be afoot that could enable clinicians to tailor treatment to individuals' specific characteristics. For instance, it has been proven that mutations in two genes called BRCA1 and BRCA2 significantly increase a person's risk of developing breast cancer. Individuals can now be tested for these mutations, allowing early detection and targeted use of therapeutic interventions. Similar progress is being made in understanding the biological basis of other common diseases. The health service needs to consider how to invest in this work and how it can most effectively be translated into everyday practice.

Risk-stratification in North West London

As part of the Inner North West London Integrated Care Pilot, patient information was combined across primary, secondary and social care providers to understand the impact of high-risk patients on services and expenditure. The data showed that the 20% of the population most at risk of an emergency admission to hospital accounted for 86% of hospital and 87% of social care expenditure. Yet despite this high concentration in expensive downstream services, only 36% of primary care resources were expended on these same patients.[41] This suggests that through better management of these patients in primary care many hospital admissions could be prevented and intensive social care support reduced, resulting in improved care with reduced costs.

Unlocking healthcare as a key source of future economic growth

All too often we think of health expenditure as solely a cost, but investment in individuals' wellbeing and productivity delivers vast benefits to society and the economy. Conversely, illness costs the UK economy dearly: in 2011, 131 million work days were lost due to sickness.[42] This translates into an annual economic cost estimated to be over £100bn whilst the cost to the taxpayer, including benefits, additional health costs and forgone taxes, is estimated to be over £60bn.[43]

In addition to preventing and relieving illness, the NHS has a central role in contributing to economic growth. The NHS is the largest single customer for the UK health and life sciences industries including pharmaceutical, biotechnology, medical devices and other sectors,[44] and Britain is recognised as a leader in biomedical research. We must consider how the NHS can work with industry partners to make sure that the health and life sciences continue to be a growing part of the UK economy.

[41] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[42] Office of National Statistics (2012), "Sickness absence in the labour market".
[43] Department of Health (2011), "Innovation, Health and Wealth".
[44] Department of Health (2011), "Innovation, Health and Wealth"

What's next?

This document discusses the key problems and opportunities that a renewed vision for the health service must address. In the next phase of work, we will analyse, with our key partners, the causes of these trends and challenges and share these more widely in order to begin to generate potential solutions. Some of these solutions may come from reviews that are already underway such as the Urgent and Emergency Care Review and the Berwick Review on improving safety in the NHS. Some solutions may be adapted from small-scale pilots or international models that can demonstrate success, but there is no doubt that new ideas are needed.

We cannot generate these new ideas alone. NHS England is committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, NICE, the Health and Social Care Information Centre, the Local Government Association,the steering group of the NHS Commissioning Assembly, Health Education England and the Care Quality Commission want to work in partnership with NHS England to understand the pressures that the NHS faces and to work together alongside patients, the public and other stakeholders to identify new and better ways to deliver health and care.

The NHS constitution stipulates that the NHS belongs to the people and so does its future. In keeping with this principle we will be working together with staff, patients and the public to develop new local approaches for the NHS. We need your help to ensure that the ideas identified are sustainable and respect the values that underpin the health service. To enlist your help, we are launching a nationwide campaign called *'The NHS belongs to the people: a Call to Action'*.

A call to action

A call to action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This programme will be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. The engagement will be patient - and public-centred through hundreds of local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

The call to action aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future.
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures.
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

What will happen with the data and views that are collected?

All data, views and information will be collected by CCGs and NHS England. This information will then be used by CCGs to develop 3-5 year commissioning plans, setting out commitments to patients about how services will be improved.

This information will also be used by NHS England to shape its direct commissioning responsibilities in primary care and specialised commissioning.

Information gathered in this way will drive real future decision making. This will be evident in the business plans submitted for both 2014/15 and 2015/16. These plans will signal service transformation intentions at both local and national level.

There is no set of predetermined solutions or options about which we are consulting. Bold, new thinking is needed and we will consider a wide range of potential options. However, there are three options that we will not be considering:

1. **Do nothing.** The evidence is clear that doing nothing is not a realistic option nor one that is consistent with our duties. We cannot meet future challenges, seize potential opportunities and keep the NHS on a sustainable path without change.

2. **Assume increased NHS funding.** In the 2010 spending review, the Government reduced spending on almost all most public services, although health spending was maintained. We do not believe it would be realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years.

3. **Cut or charge for fundamental services, or 'privatise' the NHS.** We firmly believe that fundamentally reducing the scope of services the NHS offers would be unconstitutional, contravene the values that underpin the NHS and - most importantly - harm the interests of patients. Similarly, we do not think more charges for users or co-payments are consistent with NHS principles.

How will the call to action engage people?

The call to action will offer a number of ways for everyone to engage with the development of a renewed vision for the health service including:

A digital call to action

Staff, patients and the public will be able contribute via an online platform hosted by NHS Choices. This platform will enable people to submit their ideas, hold their own local conversations about the future of the NHS and search for engagement events and other interactive forums.

'Future of the NHS' surgeries with NHS staff, patients and the public

Local engagement events will be led by clinical commissioning groups, health and wellbeing boards, local authorities and other local partners such as charities and patient groups. These workshop-style meetings will be designed to gather views from patients and carers, local partner groups and the public. We will also be holding events designed to capture the views of NHS staff, for instance, through clinical senates.

Town hall meetings

Held in major cities across the NHS, these events will engage local government, regional partners, business and the public. These regional events will give people who have not contributed locally a chance to participate in regional discussions.

National engagement events

A number of national events focusing on national level partner organisations to the NHS will be held. These will include Royal Colleges, patient groups and charities, the private sector and other stakeholders.

Conclusion

The NHS is one of our most precious institutions. We need to cherish it, but we also need to transform it. Future trends threaten its sustainability, and that means taking some tough decisions now to ensure that its future is guaranteed. We believe that by working together as a nation, we have a unique opportunity to transform the NHS into a health service that is both safe and fit for the future.

The NHS needs your help. Have your say.

<u>INTEGRATED CARE</u>

Relevant at 3 levels:

1. Strategic level informed by the JSNA and H&W Strategy
2. Local Level – person centred and outcomes
3. Development of a 24/7 integrated health and social care service delivery

- It should all be underpinned by a commitment to the definition which is 'A Narrative or Person Centre coordinated Care' and the commitments made through the National Collaboration for Integrated Care and Support;

- It should be based on shared risk and rewards

- It should be based on a join identification of people within the scope of any integration activity;

- It should be based on information sharing, tracking of expenditure and joint evaluation;

- Based on principles of maintaining people in their own home and non-institutionalised care at an individual and strategic level to community based solutions;

- Joint workforce development

- Co-production with individuals, carers and the community;

- Integrated individual assessment of a persons, physical, social and mental needs

- Adopting the national and local dignity challenge;

- Coordinated Care & Support:
  - Identified lead professional
  - Determined by the team around the person
  - Based on the particular care / support needs of each person

- Should be based on the assumption of a persons best interest;

Map of Current Joint/Integrated Care

JOINT/ALIGNED
Care Home Quality • County • Regional
Commissioning Plans/Actions With Joint Boards • Dementia – Older People • Adult MH • Carers PLD
Re-ablement beds in HOPs
S256 Projects
Falls Prevention Response
JSNA
Implementing Autism Act
Adult Safeguarding
End of Life
Stroke Services
Dementia Pathway • Memory Assessment Including CCGs/Home Care Pilot
SPA/Acute Hospital Admissions/Discharge/Winter Plan
24/7
Virtual Ward etc
SMT on CCG Boards
CCG on Accommodation & Support
Continuing Care
CSWs – Mental Health
Staff Development/Training
NHS Access to FWi

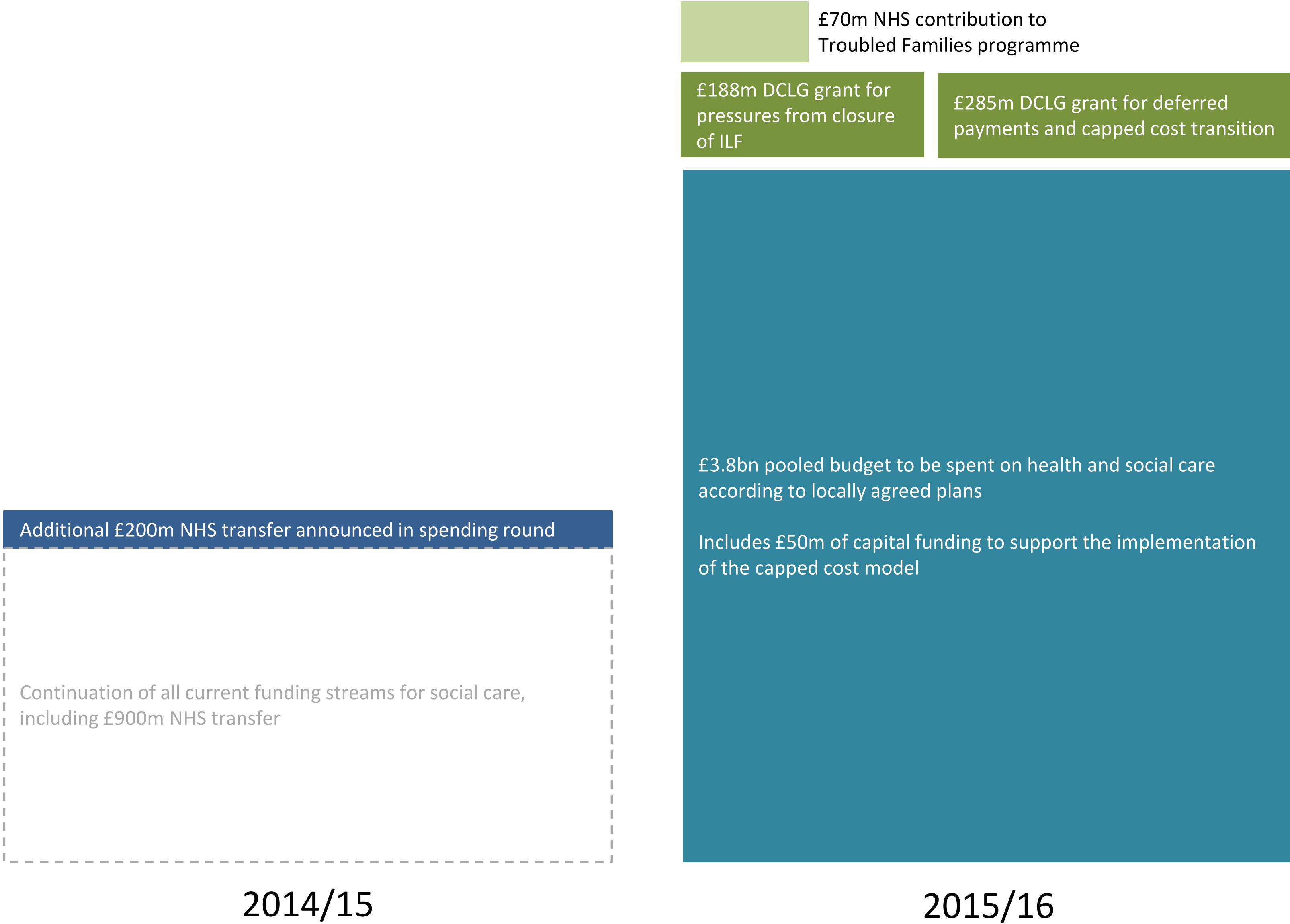
INTEGRATED
ICES
Integrated Care Beds (N&S)
Jubilee Centre/Queens Court
Carers Support and Short Breaks
Voluntary Organisations support (wide range) Including: • Advocacy • IMHA/IMCA • DOLs
Care Home Payments
Winterbourne
Francis report
Lead Commissioning PLD
Dignity in Care
Short Breaks PLD
TOTAL **£34m transactions between AC & Local NHS**

Department of Health

2013 Spending Round

Overview of the social care settlement and next steps

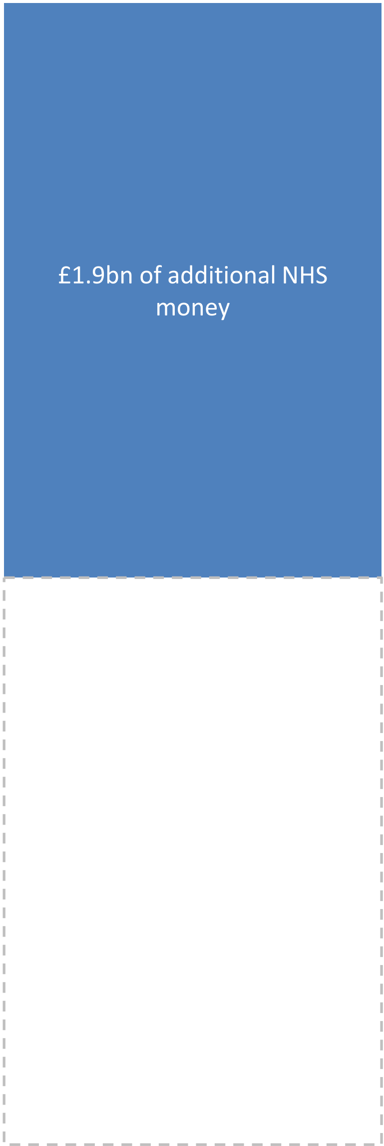
Overview of the spending round settlement for social care



How the £3.8bn integration pool has been created

With the troubled families money this makes £2bn additional NHS funding for integration

£1.9bn of existing funding from across the NHS and social care which is currently spent in areas relevant to both services…



…and £1.9bn of additional NHS money…

… will be placed in a £3.8bn pooled budget to be used across the NHS and social care.

Conditions on the integration pool

The £3.8bn pooled budget will only be released to local areas with **agreed plans** for how it will be used

Content of the plans

In general, the content of the plans will be locally agreed, but there will be some nationally mandated elements. These will include:

- protection of social care services;
- 7-day working in health and social care;
- better data sharing;
- joint approach to assessment and care planning;
- implications for the acute sector of service redesign; and
- accountable lead professionals for joint care packages.

£1bn of the funding will be linked to **outcomes achieved**

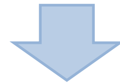
Payment for performance

Payment will be based on a combination of locally and nationally set outcome measures. Half of the funding will be paid at the beginning of each year (based on 2014/15 performance) and the remainder paid in arrears against performance in 2015/16.

Next steps

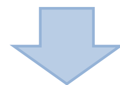
1. Publish a joint statement

We will publish a joint statement by the end of July, giving further detail on how the fund will operate, what is expected of local areas and the process for finalising details.



2. Publish full guidance

We will work together over the summer/autumn to develop full guidance for local areas, which will set out when plans need to be developed, what they need to contain and details of the assurance process.



3. Local areas publish plans for 2014/15

All areas will need plans for 2014/15, setting out how they will use this year to make progress on priorities and prepare for the implementation of the pooled budget. The deadline for publishing plans, and the assurance process, will be set out in the full guidance.

Local Government Association

NHS England

Statement on the health and social care Integration Transformation Fund

Summary

1. The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand pressures on services. In this context the announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was a real positive. The money is an opportunity to improve the lives of some of the most vulnerable people in our society. We must give them control, placing them at the centre of their own care and support, make their dignity paramount and, in doing so, provide them with a better service and better quality of life. Unless we seize this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives.

2. The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". We are calling this money the health and social care Integration Transformation Fund (ITF) and this note sets out our joint thinking on how the Fund could work and on the next steps localities might usefully take.

3. NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) are working closely with the Department of Health and Department for Communities and Local Government to shape the way the ITF will work in practice. We have also established a working group of CCGs, local authorities and NHS England Area Teams to help us in this process.

4. In '*Integrated care and support: our shared commitment*' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

5. Whilst the ITF does not come into full effect until 2015/16 we think it is essential that CCGs and local authorities build momentum in 2014/15, using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and

2015/16, which must be in place by March 2014. To this end we would encourage local discussions about the use of the fund to start now in preparation for more detailed planning in the Autumn and Winter.

Context: challenge and opportunity

6. The ITF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The ITF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years. We see the ITF as a significant catalyst for change.

7. There is also an excellent opportunity to align the ITF with the strategy process set out by NHS England, and supported by the LGA and others, in *The NHS belongs to the people: a call to action*[1]. This process will support the development of the shared vision for services, with the ITF providing part of the investment to achieve it.

8. The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work CCGs and local authorities are already doing, for example, as part of the integrated care "pioneers" initiative and Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

Background

9. The June 2013 Spending Round set out the following:

2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements.

10. In 2015/16 the ITF will be created from the following:

£1.9 billion existing funding continued from 14/15 - this money will already have been allocated across the NHS and social care to support integration
£130 million Carers' Breaks funding.
£300 million CCG reablement funding.

[1] http://www.england.nhs.uk/2013/07/11/call-to-action/

c. £350 million capital grant funding (including £220m of Disabled Facilities Grant).
£1.1 billion existing transfer from health to social care.
Additional £1.9 billion from NHS allocations Includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill. Includes £1 billion that will be performance-related, with half paid on 1 April 2015 (which we anticipate will be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in-year performance).

11. To access the ITF each locality will be asked to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met. This plan will also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

12. Plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

Conditions of the full ITF

13. The ITF will be a pooled budget which will can be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health;
- ensure a joint approach to assessments and care planning;
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

14. Ministers have agreed that they will oversee and sign off the plans. As part of achieving the right balance between national and local inputs the LGA and NHS England will work together to develop proposals for how this could be done in an efficient and proportionate way.

Conditions of the performance-related £1 billion

15. £1 billion of the ITF in 2015/16 will be dependent on performance and local areas will need to set and monitor achievement of these outcomes during 2014/15 as the first half of the £1 billion, paid on 1 April 2015, is likely to be based on performance in the previous year. We will be working with central Government on the details of this scheme, but we anticipate that it will consist of a combination of national and locally chosen measures.

Delivery through Partnership

16. We are clear that success will require a genuine commitment to partnership working between CCGs and local authorities. Both parties need to recognise the challenges they each face and work together to address them.

- Finding the extra NHS investment required: Given demographic pressures and efficiency requirements of around 4%, CCGs are likely to have to re-deploy funds from existing NHS services. It is critical that CCGs and local authorities engage health care providers to assess the implications for existing services and how these should be managed;
- Protecting adult social care services: Although the emphasis of the ITF is rightly on a pooled budget, as with the current transfer from the NHS to social care, flexibility must be retained to allow for some of the fund to be used to offset the impact of the funding reductions overall. This will happen alongside the on-going work that councils and health are currently engaged in to deliver efficiencies across the health and care system.
- Targeting the pooled budget to best effect: The conditions the Government has set make it clear that the pooled funds must deliver improvements across social care and the NHS. Robust planning and analysis will be required to (i) target resources on initiatives which will have the biggest benefit in terms outcomes for people and (ii) measure and monitor their impact;
- Managing the service change consequences: The scale of investment CCGs are required to make into the pooled budget cannot be delivered without service transformation. The process for agreeing the use of the pooled budget must therefore include an assessment of the impact on acute services and agreement on the scale and nature of changes required, e.g. impact of reduced emergency activity on bed capacity.

Assurance

17. Local Health and Wellbeing Boards will sign off the plans, which will have been agreed between the local authority and CCGs. The HWB is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process. The plans will then go through an assurance process involving NHS England to assure Ministers.

Timetable and Alignment with Local Government and NHS Planning Process

18. Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans;
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS Call to Action)
- the announcement of integration pioneer sites in October, and the forthcoming integration roadshows.

19. The outline timetable for developing the pooled budget plans in 2013/14 is broadly as follows:

• August to October:	Initial local planning discussions and further work nationally to define conditions etc
• November/December:	NHS Planning Framework issued
• December to January:	Completion of Plans
• March:	Plans assured

Next Steps

20. NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds
- Conditions, including definitions, metrics and application
- Risk-sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs.

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8 August 2013

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