Topic:	**Update from the Integrated Commissioning Executive Group (ICEG)**
Meeting Date:	**10 April 2014**
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1 Introduction

At its meeting on 13 February, the HWB formally established the Integrated Commissioning Executive Group (ICEG) as a sub-group and adopted the proposed Terms of Reference, subject to minor amendments.

One of the requirements in the ToR was that ICEG should provide a regular report on progress against key headings to each meeting in public of the HWB. This paper is the first of those reports.

Topics covered are:

- Better Care Fund
- Staffordshire System Strategic Review
- Programme Management
- Integrated Commissioning

2 Better Care Fund

As members of the HWB will be aware, DH and DCLG have agreed to promote integrated commissioning across health and social care systems, in order to secure improved outcomes for local populations, through establishment of the Better Care Fund (BCF).

The BCF has, at its core, a requirement laid down by DH for a range of existing grants, currently paid directly to CCGs, District and Borough Councils, and social care LAs, as well as transfers from NHS England to social care LAs under s256 of the NHS Act 2006, to be rolled up into a single fund. From 2015/16 onwards, this fund will be augmented by a 3% transfer from CCG budgets and will be managed as a pooled budget under s75 of the NHS Act 2006. Nationally, the BCF will then have a value of £3.8bn, equating to £56m in Staffordshire.

The position in practice has become somewhat complex, on a number of different fronts:

- *Purpose of Funding*: There appears to be some difference of view between Whitehall Departments. DCLG, in its assessment of LA spending power, has assumed that the entirety of the additional BCF funding in 2015/16 will be

transferred to social care. It has therefore set core grant levels to LAs on the basis that the BCF resources are fully available to social care. By contrast, DH (via NHS England) appears to regard the funding as additional investment, by the NHS into social care, which will fund a range of new service developments, such as 7-day working and a single named lead clinician for key patients, in order to facilitate more efficient and speedy hospital discharge.

- *Location of Risk*: Since the additional resources included in the BCF from 2015/16 onwards are drawn directly from existing CCG budgets, this requires CCGs to make significant savings from their current spending profiles. Realistically, this can only be achieved through reductions in acute hospital non-elective admissions. There is no consensus from Whitehall over where the risk regarding the measures required to deliver these savings should sit. Should the savings fail to materialise, CCGs could be left with a deficit, if they have already transferred the 3% to the BCF, or LAs could face the deficit if the funding is only transferred as the savings are generated, yet they have invested in alternative schemes. It is understood that different Area Teams have been giving different advice to their CCGs.
- *Scope of the BCF*: Although DH and DCLG have specified a minimum value for the BCF locally (based on the share of the national £3.8bn), they have strongly encouraged health and social care systems to use the BCF as a vehicle for much wider and more ambitious integration. There is therefore an element of tension between the drivers that make the BCF plan, in effect, the local implementation plan for the health and social care aspects of the JHWS as a whole and those that push it towards a focus on older people's care, especially connected to hospital admission and discharge.
- *Fit with Other Planning Processes*: The BCF is centred on the HWB as the base unit, with key milestones for submission of draft plans on 14 February, 4 April, and in the summer. The requirement for the BCF to be a single county-wide plan does not always sit entirely comfortably with the desire by individual CCGs to design bespoke solutions that suit their specific local contexts. This causes some tension, for example, given the need for plans relating to North Staffordshire to align with those for Stoke, which must produce its own separate BCF plan. This issue was noted by the HWB in January, when it was agreed that services for older people (the core of the BCF) would generally be commissioned on the basis of a CCG footprint, rather than county-wide. At the same time, all six CCGs across the county and city are required to produce a single joint five-year strategy, due for submission in June. Finally, though to the same timescale, Monitor, NHS England, and the Trust Development Authority (TDA) have launched a programme of intensive support for certain health systems (including Staffordshire and Stoke), which will include service providers (further details below).
- *Involvement of Districts and Boroughs*: The HWB has been clear that the focus of the JHWS on prevention means that Districts and Boroughs have a key role to play in securing the desired outcomes. There have therefore been strong efforts to ensure that District and Borough involvement in the BCF process goes beyond merely passporting of the current Disabled Facilities Grant. However, this has had the effect of more than doubling the number of organisations involved, resulting in significant logistical and governance challenges.

- *Assurance Process*: The assurance of BCF plans is being led by NHS England, through its Area Teams. Last minute revisions to the assurance tests, variation in interpretation and methodology between Area Teams, and a lack of clarity over whether this is essentially an NHS process or one that is joint with LAs (via the LGA and ADASS), has resulted in the exercise being less straightforward than would have been ideal. At least in part, some of these issues appear to have been addressed in very recent guidance for assurance of the submissions due on 4 April.

Locally, through ICEG, significant work has been done to develop a single BCF plan, which expresses the full ambition of the HWB as expressed in the JHWS and through the wider work on integrated commissioning (further details below), while recognising the different responses and solutions being developed in different parts of the county. The variety of those solutions has meant that it has often been difficult for the BCF plan to express more than high level principles and aspirations, as coverage of all the resulting actions would make the BCF plan itself unmanageably large and would duplicate local plans. It has also proven challenging in many cases to identify the exact areas where the resources being rolled into the BCF are currently spent, making it difficult to be clear what services would need to be stopped in order to release funds for alternative investment. Further, it has been especially problematic for CCGs to identify additional initiatives, over and above those already built into their existing plans, to release the 3% of their budget for the BCF. Should those savings not be achieved, this might well force a balancing cut in social care services, with consequent impact on hospital discharges and hence CCG costs.

At the time of writing, the team were putting final touches to the latest submission, due on 4 April, with arrangements in place to secure formal sign off as required from each of the partners. The links between partners forged through ICEG have proven invaluable in this regard.

3 Staffordshire Strategic System Review

Monitor, NHS England and the TDA have launched a process of intensive support for eleven health and social care economies across England. The Staffordshire and Stoke economy is the only one of those areas within the West Midlands, but it is understood that the Eastern Cheshire economy, which includes part of the UHNS catchment, is one of the other ten.

The work will start at the beginning of April and run through until June, designed to support the six CCGs in the county and city to develop their five-year strategy. KPMG have been selected through a tender process to provide external support, focused on diagnosis, solution development and evaluation, implementation planning, and implementation. Significant capacity will be available.

Although Graham Urwin, as the local NHS England Area Team Director, will act at Senior Responsible Owner, on behalf of Monitor, NHS England and the TDA, he has been clear that he wishes the work to be owned and driven locally, with the two HWBs taking a leading role, based on delivery of their JHWSs.

A briefing event has been organised for 11 April, to allow all stakeholders to be brought up to speed and for governance arrangements to be agreed. It is anticipated

that the two HWBs, through a sub-set of their members, will provide ongoing strategic direction to the consultants, while a sub-set of ICEG members will provide technical support and guidance, within the overall control of the work that will sit with Graham. Representatives from the wider stakeholder system, including providers, are also likely to be involved in both groups.

ICEG will seek to support the HWB in playing a central role in ensuring alignment between this work and that on the BCF, wider implementation of the JHWS, and integrated commissioning.

4 Programme Management

Since the HWB signed off the JHWS, which identified 12 priority areas for action, it has proven challenging to secure the most appropriate balance between a reporting structure that allows the HWB, via ICEG, to maintain a clear sense of progress, hold priority leads to account and identify barriers that require senior level input, while minimising bureaucracy and additional burdens on service areas.

ICEG has agreed that a vacant Commissioning Manager post within the former Joint Commissioning Unit, hosted by SCC, should be refocused in order to deliver this function, drawing on administrative support as necessary. The intention is to operate a light touch system that provides the HWB with a brief update report on the programme as a whole, with headlines from each of the 12 areas, and highlights issues for HWB consideration and action on an exception basis.

The post is currently going through the SCC recruitment approval process and is expected to be open to all NHS and LA staff, with arrangements in place to avoid the need for individuals to transfer to a different sector and hence lose continuity of employment. There is no net additional cost to the partners, as the funding for the post will be drawn from the existing JCU pooled fund. Once that fund is replaced by the proposed new integrated commissioning arrangements, the post will need to be funded through the BCF. The net effect will continue to be nil, as resources will be released through termination of the JCU s75.

Although the HWB-level programme office arrangements are not yet operational, it should be noted that significant work has already been undertaken in each of the 12 priority areas, given that these all reflected existing areas of interest across the partners. For example:

- *Drugs and Alcohol*: Incidents related to drugs and alcohol represent a significant proportion of cases where the police are required to use powers under s136 of the Mental Health Act to secure an individual in a Place of Safety. A cross-system working group, chaired by the Police & Crime Commissioner and involving the Police, all CCGs, Public Health, both Local Authorities, and both Mental Health Trusts, has made considerable progress in developing and implementing an approach to reduce the number of people detained in police cells, rather than in a mental health facility.
- *Parenting*: SCC has been undertaking a major review and redesign of its Children's Centres, with the intention of redirecting the limited resources available towards a service that is focused on maximising parenting impact.

- *End of Life*: The programme supported by Macmillan, which has won national Pioneer status, has been taking forward to identify the scope of cancer and end of life care and has recently issued PINs to test market interest and opportunities focused on key patient pathways.
- *Frail Elderly*: This provides the major focus of the core work on the BCF. CCGs and SCC, along with NHS and social care providers, have been developing a range of initiatives designed to support people in the community, maximising their independence and the capacity of communities to take responsibility for themselves, and thereby reduce unnecessary hospital admissions.

5 Integrated Commissioning

At its informal meeting on 9 January, the HWB discussed the principles and practicalities around taking the next step in developing integrated commissioning arrangements, as a means to deliver the ambitions within the JHWS in ways that maximised the impact of the limited commissioning capacity available to individual partners. Since that date, work has been progressing on two fronts in parallel.

The HWB agreed that work should be taken forward on the following topics:

- Older People: CCG footprint
- Mental Health: System-wide (county and city) strategy, with implementation on a north / south basis
- Learning Disability: System-wide (county and city)
- Children: County-wide, starting with community health and social care, but seeking to expand
- Technology (as an enabler): County-wide basis, linking with the existing ICES s75 arrangements, DFGs and the Home Improvement Service, as well as digital solutions
- Alcohol and Drugs: County-wide basis, focused on Public Health and the Police

Building on existing joint commissioning arrangements wherever these exist, work is being taken forward to identify the scope of each of these topics and to determine the shared priorities, services and funding streams. This is developing a picture for each area of the core strategies required to promote the vision and principles behind the JHWS and the practical commissioning tasks required to realise these.

This work is perhaps most straightforward where there are existing arrangements and the approach is system-wide. Outline proposals have been developed for Learning Disability and Mental Health, which will provide the basis for more detailed discussions between partners. Scoping work has begun for Children's commissioning, with a group bringing together SCC, the CCGs (north and south) and Public Health.

More complex is the topic of Older People, where the HWB agreed the focus should be on delivery on a CCG footprint. While this offers scope for tailored arrangements to suit the particular demographics and hospital configurations of each area, it also brings complexity. The recent decision by the Secretary of State to accept the TSA recommendations for MSFT means that the patient flows and catchment areas for

the existing NHS Trusts will be changing. There are also some tensions between this local focus and the statutory requirement on SCC to ensure that there is consistency of access and treatment of social care service users across the county. Similarly, the requirement for a single BCF plan, drawing from a single pooled fund, does not immediately sit comfortably with a devolved commissioning arrangement. In order to facilitate the move towards integrated commissioning, SCC has taken formal steps to develop in new ways the integration of services already achieved through its s75 agreement with SSoTP.

All of these arrangements will be based on s75 agreements. Work is also proceeding well in the area of Drugs and Alcohol. Since this is primarily a connection between Public Health and the Police, different statutory powers are required and so this work is being handled separately, though with efforts to ensure consistency and learning regarding principles and governance.

In parallel with these topic-specific actions, work is also being taken forward to develop the generic governance arrangements. These are of especial importance, as experience underlines that robust governance, which provides reassurance to all partners while ensuring the integrated team has a firm grip on commissioning decisions, is fundamental. In general, it is weaknesses in governance that cause integrated commissioning relationships to fail.

In order to address these issues, work has begun to identify a basic governance model (nicknamed the ‘vanilla’ model), which can then be customised for each topic area as required. The benefits of starting from a common base are significant, in terms of both speed and ease of producing the resulting agreements, ensuring key issues are addressed once for all, and facilitating smooth delivery through consistency.

The basic ‘vanilla’ model is likely to be grounded on the principles that:

- Every partner organisation should have a full voice in setting the direction of the integrated commissioning activity, consistent with maintaining a shared approach (thereby securing ownership).
- Decisions over that direction should be reached through a partnership board with delegated powers, without the need for members to refer back to their individual organisations (thereby ensuring smooth decision making).
- The integrated commissioning team should have full authority over the funding for the services provided by the various partners, with the ability to deploy this within the remit set out by the partnership board (thereby ensuring coherent engagement with providers).
- Whether resources are pooled or aligned should be determined by reference to the nature and needs of the topic, rather than generic principle. Whatever the approach taken (pooling or alignment, or a combination), there should be a process for the contributions of partners to be revised on an annual basis, to reflect changes in funding availability and population context, matched by an understanding of the relative contributions by different partners to the various commissioned streams of activity (thereby avoiding loss of flexibility or perceptions of inappropriate cross-subsidy).

- Resources should be ringfenced (thereby ensuring transparency over contributions and their use).

In order to ensure that these complex issues are fully recognised and addressed, expert external advice is being secured. There may also be a need for support to achieve a shared understanding of the nature of integrated commissioning and the attitudes required.

It is recognised that the process of moving to integrated commissioning is highly sensitive. Partner organisations will be required to give up some degree of control over their financial resources and to accept others acting on their behalf, while remaining themselves accountable for the results.

In order to ensure a continuous sense of ownership, and to seek to flush out barriers and issues at the earliest possible point, progress on the development of integrated commissioning arrangements will be taken through the formal governance of partner organisations on three separate occasions:

- Approval in principle (February / March) – Following the discussion at the HWB, a paper setting out the principles and topic areas for integrated commissioning has been taken to all of the partners to secure initial approval to proceed.
- Approval of 'heads of terms' (September / October) – Once the scope of each topic area has been determined, and the basic nature of the governance arrangements worked out, approval will again be sought. Once this has been secured, it is expected that the teams will start to form and to operate in shadow mode, enabling them to lead the process of developing the service specifications required for the 2015/16 contracting year.
- Approval of formal s75 agreements (January to March 2015) – Drafting of the legal agreements will be a complex process, requiring detailed negotiations. The need for significant legal input means that this is where the bulk of the associated costs will be incurred. Signatures will be required by 31 March, in order for contracts to be in place for 2015/16.

An outline project plan is attached at Annex A.

9 Recommendations

The HWB are asked to:-

- Note the contents of the report.
- Give retrospective approval to the BCF plan submitted on 4 April.
- Approve the approach proposed for taking forward integrated commissioning.