Event report

THE NEW NHS COMMISSIONING LANDSCAPE IN LONDON – WHAT DOES IT LOOK LIKE?

23.07.2014

VENUE

London Funders
314 – 320 Grays Inn Road
London
WC1X 8DP

In April 2013 the structure of the NHS in London changed fundamentally and over the last year the NHS in London, together with local authorities and the voluntary and community sector has been developing the new commissioning and delivery structures in the capital. Whilst this process of implementation and development continues, our July Funders Forum provided an opportunity for members to be briefed on the new NHS commissioning landscape in London, to look at some of the new voluntary and community sector delivery vehicles that are being developed, and to consider some of the challenges facing London's civil society engaging in this brave new world, and what can other funders do to support Civil Society engagement and, if appropriate, themselves engage in this new landscape.

The aims of this meeting were:

- To brief members on the new NHS commissioning landscape in London, and to consider how it is working
- To provide members with an insight in to some of the challenges facing the voluntary and community sectors in engaging with the new commissioning structures, and responses to these challenges
- To hear from the experience of London local authorities on how they are fulfilling their public health responsibilities

Although the Act did represent a major change, it is also a continuum of what has been happening for the past 20 years.

Michael Bell – Chairman NHS Croydon and Director of MBARC Ltd

Michael's powerpoint presentation is available to download here.

Michael presented a detailed overview of how the new NHS commissioning landscape looks in theory, and how it is working in practice.

The scale of the Financial Challenge

Michael began by outlining the context and background which lay behind the Health and Social Care Act 2012. Although the Act did represent a major change, it is also a continuum of what has been happening for the past 20 years and this context is very important in order to fully understand commissioning opportunities.

During the 2010 election, the Conservative Party committed to a real time increase in funding of the NHS. However, whereas from 1949 to 2010, the increase in NHS expenditure was on average 4% above expenditure per annum, from 2011 to 2015, the increase in NHS expenditure was only 0.1%. The funding requirement has increased from £110 billion to £131 billion, and this has led to a funding gap of £20billion in 2015. A return to the previous 4% annual growth rate, in the absence of substantial tax increases, would require a further seven year freeze on all other public expenditure, and so is extremely unlikely.

The increase in requirement is caused by various factors including an increased population, changing demographics (an aging population) and technological advance leading to more expensive treatment options.

The Health and Social Care Act 2012

The Act is predicated on management cost reductions, and 'bottom up' patient and clinical engagement. There is a focus on clinically led commissioning and the idea that

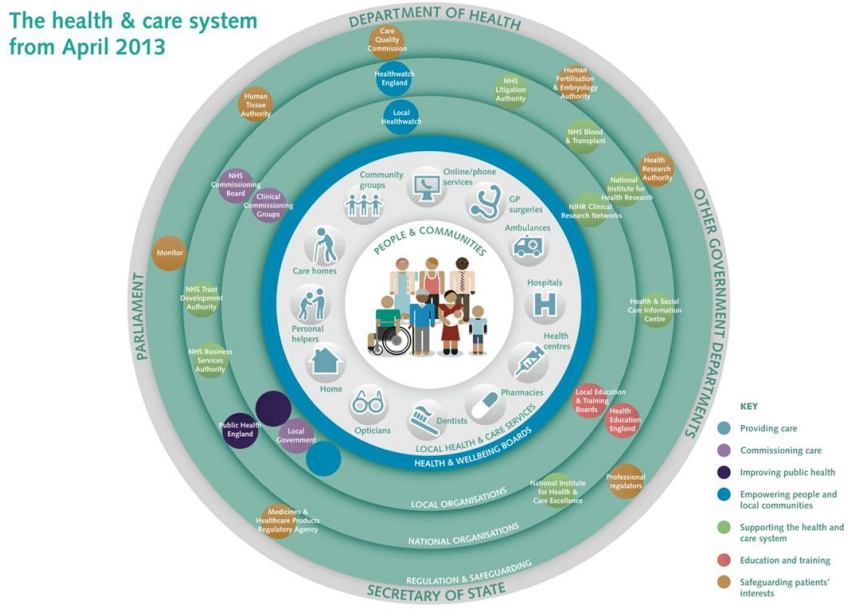
any qualified provider, including NHS foundation trusts, would be free to deliver services. The emphasis of measurement would now be clinical outcomes.

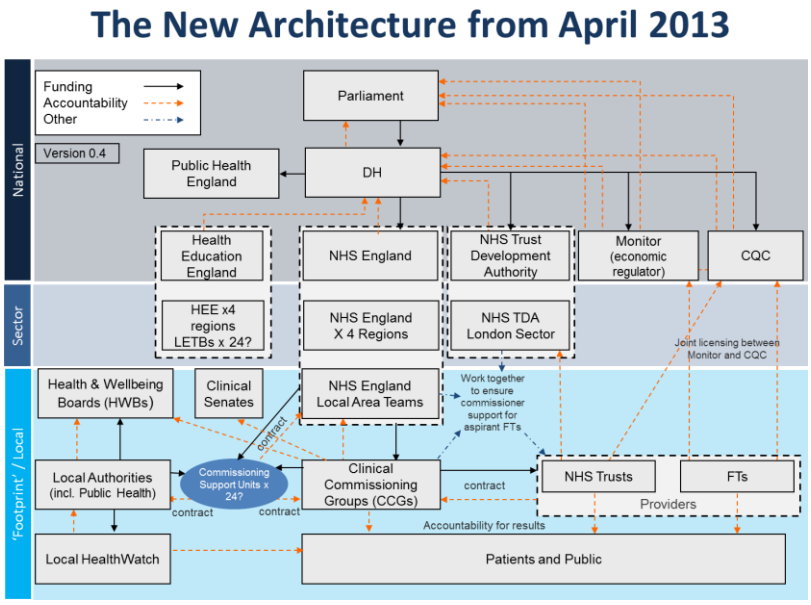
A new commissioning landscape

The Act saw a very dramatic initial change when it came into effect on 1st April 2013. On 31st March 2013, 7 organisations were responsible for commissioning NHS healthcare services in London. However, the next day, on 1st April 2013, 74 organisations were responsible. These numbers though have now started to decrease and level off.

The diagrams below show the structure of the NHS following the Health and Social Care Act 2012. Some changes include that NHS England is now responsible for the commissioning side, but not services, and there is a bigger focus on mental health. More information can be found on the specific roles of the different parts of NHS England in Michael's powerpoint presentation.

On 31st March 2013, 7 organisations were responsible for commissioning NHS healthcare services in London. The next day on 1st April 2013, more than 70 organisations were now responsible





The local Commissioning architecture:

- Clinical Commissioning Groups- these are clinically led and operating at scale. These structures manage primary care commissioning, including holding the NHS Contracts for GP practices
- Commissioning support services – they were intended to provide support to Clinical Commissioning Groups by providing business intelligence, health and clinical procurement
- Local authorities have, since 1 April 2013, been responsible for improving the health of their local population and for public health services including most sexual health services and services aimed at reducing drug and alcohol misuse. The Local Authorities have had a 27% cut of their budgets and, except for public health money, there has been an end to ring fencing. The local authorities have a new role in the Better Care Fund and a central role in JSNA and Health and Wellbeing Boards.

Between 2010 and 2015 Local Authorities will have had a 27% cut to their budgets

<u>The changing provider landscape</u>

The emphasis is now on 'any qualified provider', though regulation is a very important part of the system.

In the acute sector (hospital side), the Act envisaged a mandatory move from NHS Trust status to Foundation Trust status (or transfer to another organisation in the NHS or outside) although there is now increasing flexibility in possible models. This is within the context of challenges around Care Quality (Post-"Francis"), financial viability and the PFI legacy. There is a possible role for the independent sector in mergers, acquisitions and disposals and clinical and financial pressures for radical reconfiguration (including hospital closures across London).

The emphasis is now on 'any qualified provider'

Mental health and Community Health services have seen substantial changes arising from Transforming Community Services agenda which saw the transfer of PCT provider services to new organisations. For Mental Health services 'Parity of Esteem' has emerged as an attempt to ensure mental health has same as physical health.

Primary Care services (GPs and Pharmacy) have been subject to less change but hey are facing increasing demands from the public within static or reducing budgets. There is a new statutory duty to secure continuous improvement in primary care

What may happen in the future?

- Continued pressure to invest in community based services and disinvest in hospitals
- Expanding role for local authorities
- Increased emphasis on self-management and early intervention
- A greater role for Academic Health Science Networks
- More specialisation by hospitals
- Larger multi-purpose primary care services

The trajectory is not changing that much. It has already been a 20 year journey, and it's not finished yet. There are opportunities for the third sector in this as a range of support will be needed and the VCS are an untapped resource to support the NHS. Commissioning should be about needs and not just about continuing and adding to what we have been doing.

Shani Lee – Chief Executive Desta

Shani's powerpoint presentation is available to download here.

Owned and controlled by its members, Desta is the outcome of a £500,000 investment by Hammersmith & Fulham voluntary organisations and was set up expressly as a vehicle to enable the local voluntary sector to compete for public sector contracts. Desta delivers the Expert Patient Service in Hammersmith & Fulham, Kensington & Chelsea and Westminster on behalf of Central London Clinical Commissioning Group (CLCCG). It has a second contract, also with CLCCG, to develop health awareness training for carers.

Shani outlined the timeline of Desta's history and the establishment of the consortium. Desta delivers social impact that would not otherwise be achieved, either by fragmented voluntary sector suppliers or by private sector competitors by allowing small organisations to work together with others and be involved in bids, however challenging partnerships may be. A part of the infrastructure in the sector, Desta helps front line voluntary organisations achieve what they want to, by giving a single point of contact to the sector along with a business focus and making engagement with the voluntary sector a lot easier.

Shani gave a full explanation of the types of services which are offered, and Desta's strategy for growth and business plan. Desta has the potential to be a provider of scale, with 55 members to date, and another 17 waiting to join and £60 million per annum aggregated income. A key to Desta is that, as a very formal consortium with an independent legal entity, membership requires a very formal rigorous application process and this quality assurance is very important. There will be challenges though, and Desta will require a long term investment and a strong CVS in order to support the model.

Desta has the potential to be a provider of scale, with 55 members to date, and another 17 waiting to join

Alice Wallace – Head of Special Projects (VCS) Camden & Islington Public Health

Alice's powerpoint presentation is available to download here.

Alice Wallace talked about the opportunities, benefits and challenges in involving the voluntary and community sector in addressing health inequalities.

Beginning with the context, Alice provided an introduction of the demographics in Camden, noting that Camden is a young and growing population, expecting an 11% increase in population. Diversity is increasing, however there is an unequal distribution of health outcomes (a 12% difference in life expectancy between the poorest and most affluent areas) leading to significant challenges. The Joint Strategic Needs Assessment [JSNA] has highlighted that smoking is a large contributor to health inequalities, people with mental health problems also experiencing poor physical health, and that access to sexual health and contraceptive services are key. The 3 key pillars of public health

were noted as health improvement, health protection and health services, and that there is room for VCS involvement in each area.

Camden council aims to build individual and community resilience by investing in its local VCS to maximise its special value for residents. This work is underpinned by an understanding that the VCS is trusted by those who don't generally engage with public or private sectors, it is proactive and preventative, self-organising and has topic expertise and hyper-local knowledge which makes it well placed to make a major collective contribution to the local community.

Alice argued that the VCS is a huge resource to be tapped into, and that currently there needs to be spaces for the key players to join together. To maximise new opportunities over the next 12 months, the following actions are needed:

- Engagement with the VCS. The sector has a huge amount of information on local health needs – we need to find the most appropriate ways to access that information. And the sector is doing some really exciting & innovative work.
- Understanding council spend and the impact of cuts. We need to know who our key providers are – and what they are delivering. Also the risk if they should get into financial difficulties. We need to also understand the local interdependencies – what are the implications of a particular organisation getting into difficulties. There are also opportunities as councils outsource services, especially if health agencies engage with the market early and facilitate appropriate development.
- It's important to promote good examples of good practice in the VCS, and also looking at the role of grants as well as contracts. Examples will help others to unlock their potential, so any positive examples should be collected.

The VCS is a huge resource to be tapped into

However, Alice noted that there are also challenges to involving the VCS fully. These include the significant reductions to public sector budgets; the strength of local relationships; how we communicate with each other (commissioners are not always clear on the impact of the VCS); evidencing how the VCS is representing different communities and VCS agility and the capacity from colleagues in both sectors to engage in partnership work.

Alice detailed several positive examples of good practice from Camden and where progress has already been made.

Questions and conversation

The group discussed various points in more depth:

- Where is leadership coming from? London governance is fractured. Although some examples of joint working, e.g. tri-borough, are coming through, it is very difficult to get that leadership and find your way into the system. Commissioners generally respond to local need, but it is a challenge where there are not collaborations and there is more that the sector could be doing to help this.
- Provision versus need. There has been a reduction in management and capacity is stretched: it's important to drive by needs rather than

it is essential to be committed to partnership and collaboration

provision. Since 2010 the number of mergers has decreased by 50% and the number of organisations has increased 10 fold. Although there are quite a lot of levers, someone needs to make this available so that organisations can get into the commissioning process and influence the direction of travel.

- Academic research is often left out. This is something that will be changing as there is a lot of important work taking place. Local Authorities have got responsibility for health scrutiny and can scrutinise CCGs, acute trusts and the health and wellbeing board. This information is potentially available to use and this is an important part of the lever.
- Chain of accountability. Locally devised solutions influence the top and this is the best way to create change. You need to work with the top to influence the mood, however working at grass roots is effective as the vast bulk of money is decided locally.
- To date there has been no analysis of CCG spend. More providers are being funded but it's not known in what sectors this is. The system is rapidly moving and there are lots of providers coming in. Consortia are needed to pull people together to access the money.
- 'Parity of esteem' is one of the 5 core objectives, though it will require vigilance to achieve this.

David thanked the participants and speakers for a very full conversation. With so much information and such rapid changes in the sector, London Funders will follow up with another, more in depth, meeting on this topic soon.

Participants

Kerry	Luker	BBC Children in Need
Russell	Darbon	Big Lottery Fund
Christine	Chang	Big Society Capital
Alice	Wallace	Camden and Islington Public Health
Jemma	Mindham	CSV
Helen	Stack	CSV
Shani	Lee	Desta
Nerissa	Santimano	London Borough of Barking and Dagenham
Malcolm	John	London Borough of Harrow
Marcia	Dillon	London Borough of Lambeth
Winston	Castello	London Borough of Lewisham
Melissa	Watson	London Borough of Richmond Upon Thames
David	Olney	London Borough of Sutton
Maura	Farrelly	London Borough of Tower Hamlets
Victor	Willmott	London Catalyst
Victoria	Warne	London Community Foundation
Michael	Bell	MBARC
Tony	Li	Mind
David	Bull	New Philanthropy Capital
Nicola	Bristow	Oak Philanthropy (UK) Limited
Lara	Pereira	Royal Borough of Kingston upon Thames
Palma	Black	Southern Housing Group
Joanna	De Havilland	The Tudor Trust

In attendance

Becky	**Green**	London Funders
David	**Warner**	London Funders