The new commissioning landscape

October 2011

Andrew Webster

Health Reform

- Equity and Excellence: *Liberating the NHS* describes a system with:
  - **Patients** at the heart of everything
  - **Outcomes** among the best in the world
  - **Clinicians** empowered to deliver results
- To achieve this, it proposes:
  - Clinical Consortia;
  - An autonomous NHS Commissioning Board;
  - A new role for local authorities; and
  - All NHS Trusts will become foundation trusts (FT), or be part of an FT

Public Health - Healthy Lives, Healthy People

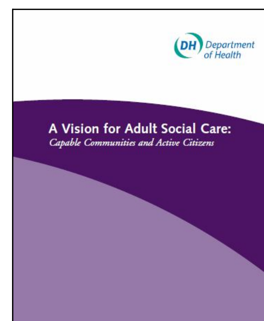
- Directors of Public Health (DsPH) jointly appointed by Public Health Service and Local Councils; employed by Councils;
- Councils, through DsPH, lead on health improvement with ring-fenced budget;
- First allocations to Councils in April 2013;
- Outcomes framework for Public Health Service;
- Councils free to define contribution to national outcomes;
- Public Health Service will need to work closely with the NHS

- White Paper response now published and in process

A vision for adult social care: Capable communities and active citizens

This vision demonstrates the Government's values of freedom, fairness and responsibility, shifting power from central to local, from state to citizen, from provider to people who use services, including their carers.

- Based on seven principles –
  - **personalisation**
  - **prevention**
  - **plurality**
  - **productivity**
  - **partnership**
  - **protection**
  - **people**



- Think Local, Act Personal

Social Care: The need for change

- Increases in **demand**:
  - number of older people is projected to increase, reflecting the ageing of the people born between 1946 and 1964 – the 'baby boomer' generation.
  - increase in life expectancy - by 2026, there will be twice the number of people aged over 85 than there are now, and the number of people aged over 100 will have quadrupled.
  - number of adults with a learning disability is increasing, primarily as a result of falling mortality.
- Increased **expenditure:**
  - Office for Budgetary Responsibility suggest that by 2029/30 government will be spending 1.7% on long-term care, compared with 1.2% in 2009/10.
- **Expectations:**
  - Our expectations of the range, type and quality of social care that should be available are increasing.
  - Public concern about the quality and accountability of services and providers
- Intergenerational **fairness:**
  - Proportion of people of working age, compared with those over retirement age, is shifting. In 2008, there were 3.2 people of working age for every person of state pension age - projected to fall to 2.8 by 2033.
  - Different wealth profiles across generations - those aged 65-74 hold an average household wealth of £285,000 (excluding private pensions).

The challenge for social care funding reform

- The independent Commissioned, chaired by Andrew Dilnot, has recommended:
  - Cost cap of £35-50,000 for any individual
  - Additional funding to establish sustainable base
  - Local delivery of assessment, eligibility and support planning
  - Government support for insurance and individual future provision
  - Further consideration of other income streams

Health and Social Care Integration

- **Health and Well-being Boards** to drive the commissioning process at the local level
- **Joint Strategic Needs Assessments** & **Joint Health and Well-being Strategies**
- **New legal duties** to encourage and consider joint working arrangements
- Aligned **outcomes frameworks** for NHS, public health and social care
- Broader scrutiny remit for Local Authorities
- Strengthening the role of the **Care Quality Commission**
- Extending the remit of the **National Institute for Health and Clinical Excellence (NICE)** to social care
- Establishing **HealthWatch** to champion the voice of people using services and carers across both health and social care
- Financial incentives

The opportunities of change

- Help people with care needs and those who provide care to make a valuable **contribution to the society** and to the economy;
- Support **carers** in the workforce to continue in work, as well as care;
- Create **sustainable quality** and trusted assurance
- Create new opportunities for people who wish to **work** in the social care market;
- **Reduce poverty** by helping people to remain more independent for longer and thus participate fully in their communities – reducing loneliness and social exclusion;
- Stimulate **innovation** in social care market – mutuals, social enterprise, micro enterprises, technology that could increase value for money, quality and users' choices.

Evolving new landscape

- **Personalisation** – every care user to be routinely offered self directed care and a personal budget, extend personal budgets in health – a more *retail* system demanding better information
- **Prevention** – whole community and individuals expected to work together to prevent ill health and need for care – commissioners as *co-investors*
- **Plurality** – commissioners expected to assist *diversity*, innovation, new providers
- **Productivity** – continuing pressure on resources and attention on *better value* in the *whole* care pathway
- **Partnership** – services *working together*, providers working together to deliver the best outcomes
- **Protection** – stronger systems for *safeguarding* at local level and increased voice for care users through Healthwatch
- **People** – continued recognition of need to recruit and *develop* the right skills