A graphic of several purple puzzle pieces scattered across the page. One large piece on the left contains icons for a calculator with a pound symbol (£), a nurse's head with a cross, and a person walking. Other pieces are empty.

CCN

COUNTY COUNCILS NETWORK

County Devolution

Our Plan for Government
2015-20

Health & Social Care

#CountyDevo

March 2015

www.countycouncilsnetwork.org.uk

Background

In the UK, the number of people of state pensionable age is projected to increase by 28% from 12.2m to 15.6m by 2035. The well documented impact of an ageing population has already had profound consequences for UK public policy since 2010 and is only set to increase over the coming Parliament.

Since 2010 there have been 26% reductions in adult social care budgets, the equivalent of £3.53bn. The LGA estimates that the funding gap between March 2014 and the end of 2019/20 for adult social care is an estimated £4.3bn.¹ Health faces similar funding pressures. The NHS Five-Year Forward View estimates that by 2020 the health service will face a funding gap of £30bn.²

To address these long-term financial and demand-led pressures, the Coalition Government has introduced a set of wide-ranging reforms to both health and social care.

The Health & Social Care Act created a new framework for the delivery of health services in England, abolishing Primary Care Trusts. Health commissioning responsibilities were passed to GP led Clinical Commissioning Groups (CCGs), with public health responsibilities returning to upper-tier local authorities. Health and Wellbeing Boards (HWBs) were also created within upper-tier authorities to set the strategic direction of health provision within local areas.

The Care Act streamlines existing social care legislation, extending user rights and local authority duties and provides a statutory footing to embed and extend personalisation, preventive care and integration. Crucially, the Care Act introduces a new funding framework for adult social care, with a cap on eligible care costs for people over 25 of £72,000 and extended means-test threshold for residential care.

Alongside these major legislative changes,

the £3.8bn Better Care Fund (BCF) and 14 'integration pioneers' were announced during 2013 to push forward the Government's focus on integration. The BCF creates a local pooled budget for 2015/16 to incentivise the NHS and local government to work more closely together and promote investment in joined-up community and preventative services.

More recent announcements on health and social care integration have seen a decisive move towards promoting bottom-up, locally led, health and social care integration.

The Government's memorandum of understanding to devolve the entire £6bn health and social care budget in the Greater Manchester region from April 2016 is widely regarded as a ground-breaking development on health and social care devolution. Under the plans, local decisions on spending on hospitals, GPs surgeries and drop-in centres will be made under the accountability of an Elected Mayor, the 10 councils, 12 clinical commissioning groups, 15 NHS providers and NHS England.

The deal in Manchester has been followed by further measures to promote new 'localised' models of health and social care integration. As part of the NHS Five-Year Forward View commitment to a 'mixed model' of health economy accountability, NHS England and its national partners have announced a new programme to focus on the acceleration of the design and implementation of new models of care through 29 'vanguard' areas.

Whilst these recent developments are clearly the most vivid demonstration of this Government's commitment to the principles of localism and service integration, with increased responsibility for CCGs and local authorities, the challenges facing county health and social care systems requires equally radical change across all areas of the country.

Older Persons Relative Needs Formulaⁱ

Funding per resident aged over 75

£1,957



Inner London

£978



Metropolitan Authorities

£816



Outer London

£691



Unitary Council

£496

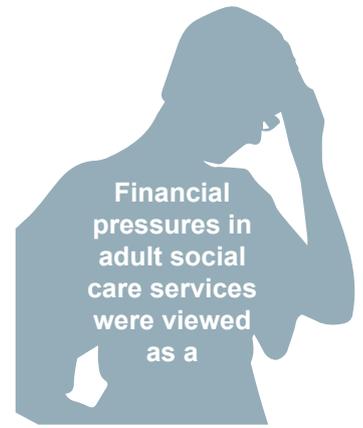


County Council

County Financial Pressuresⁱⁱ



that adult social care was the biggest financial pressure facing their council.

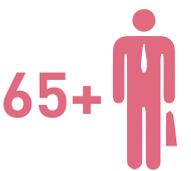


Financial pressures in adult social care services were viewed as a long-term issue by 96% of respondents.



County Demand-Led Pressures

Ageing populationⁱⁱⁱ



65+

20%
CCN member council

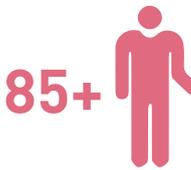
11.5%
London



75+

9.2%
CCN member council

5.4%
London



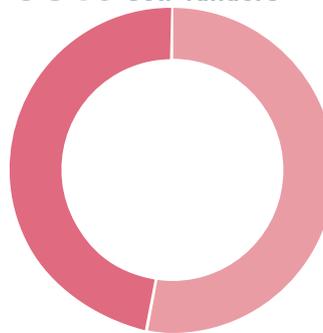
85+

2.7%
CCN member council

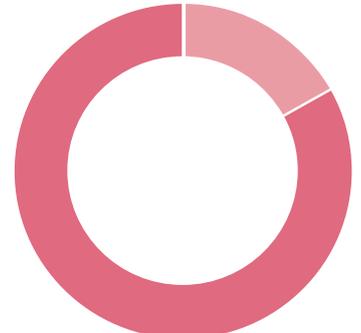
1.5%
London

Service user profile^{iv}

Counties have on average 53% self-funders



Some counties as high as 80%



Current & future demand higher in counties

County Context

The recently published *State of Care in Counties* demonstrated that counties' unique geography, demographics, and service user profile intensify the financial instability and demand-led pressures threatening the long-term delivery of social care services in England.

Although there is much to welcome in Coalition legislation aimed at addressing these long-term challenges, the combination of funding reductions, growing demand, the future implications of the Care Act and radical reforms have had a mixed impact in county areas.

The move to locally-led clinical commissioning via CCGs and return of public health responsibilities to upper-tier authorities are welcome developments, but the Health & Social Care Act and prevailing centralised model of the NHS continues to create barriers to health and social care integration.

Questions remain over the capacity of many CCGs, including their long-term financial viability and effectiveness as singular commissioning units.³ CCN member councils have also raised concerns that non-conterminous and overlapping CCG boundaries have also brought additional complexity and competing priorities in many large county areas.

HWBs have introduced an element of democratic oversight to services, and are potentially a powerful vehicle for whole-system integration across providers; but they currently lack the powers and resources to lead a truly localised, democratically accountable, approach to integrated care and support.

Alongside integration and commissioning challenges, a recent analysis by the Kings Fund of the Health & Social Care Act argued that new systems of governance have resulted in increased system complexity and a 'vacuum' of accountability and local leadership.⁴

Fragmentation and organisational complexity is present across England. However, it is more significant in larger county areas with vast numbers of different commissioners of primary, secondary and public health services.

The introduction of the Care Act and BCF have been an important catalyst for increased integration amongst local partners, but the BCF continues to be held back by a range of centrally imposed restrictions and the Care Act presents significant new financial pressures. The County APPG comprehensive analysis of integration and the BCF showed the programme has thus far been beset by an 'over-centralised approach which generates bureaucracy' that threatens to scupper local working relations.⁵

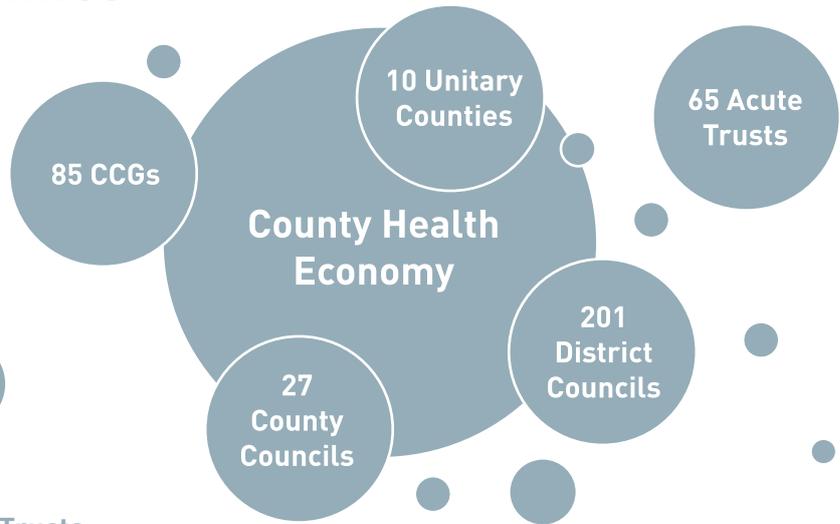
Although locally led health and social care integration has been a stated objective of all these reforms, they have done little to change the centralised nature of the NHS. Crucially, they also continue a one-size-fits all, centrally imposed and dictated, model of integration.

Devolution proposals in Greater Manchester and the 29 vanguard areas show that the Government acknowledges the need for change. There is now a strong appetite for new localised models of health and social care delivery, with NHS England backing a 'mixed model' of health economy accountability.

If the case for devolution in Greater Manchester can be made where current demand is *less* acute, geographies and service provision *less* complex and future pressures *less* severe, why not in county areas? A County Devolution Settlement must explore the decentralisation of the NHS and devolution of greater health and social care powers to counties too. Our counties with their unique demand pressures and health economies require specific devolution proposals across health and social care.

Complex Health Economies^v

In CCN member councils there are:

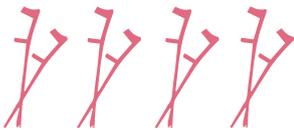


In London there are 32 CCGs & 14 Acute Trusts.

Pressures are impacting on local services...^{vi}



Delayed discharges up **29%** in counties
Median average for CCN member councils during 2013-2014



Delayed discharge rate **43%** higher in counties
Compared to national average



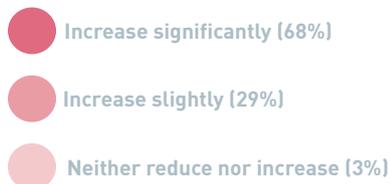
Delayed discharge days **29%** higher in counties
Compared to national average

Funding and Policy Changes

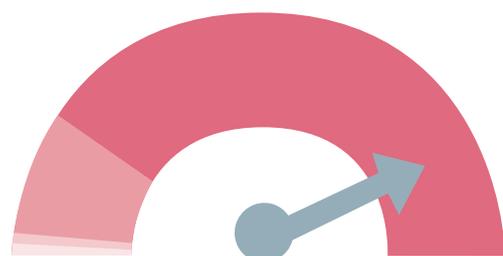
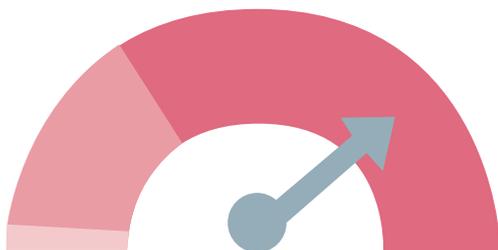
County leaders say the Care Act will increase financial pressure.

How the Care Act changes things

97% of respondents thought that Care Act duties from 2015 would increase the funding pressures.



80% thought that changes from 2016 - the Dilnot reforms - would increase pressures significantly



Call for Evidence: Cornwall

For Cornwall, integrated care means shaping the whole system (beyond health and care) around the individual. To achieve this Cornwall would use the powers of the Health and Wellbeing Board to commission primary, secondary and social care services in order to provide an oversight of local public funding for health and wellbeing in Cornwall. Their ambitions are, however, stymied by conflicting government department policies, different NHS and local authority financial and legal legislation and non-aligned nationally prescribed systems that hinder joint working.

Cornwall wants to work with Government to develop solutions to address issues including:

- The greater integration of health and social care commissioning and provision
- Financial disincentives in the systems between providers to support a truly person-centred approach where the individual can access the right care, at the right time in the right setting.
- A solution to the current financial frameworks where social care is means tested or privately funded whereas NHS is free at the point of contact ring-fenced and paid for out of general taxation which is a barrier in addressing people's needs in the current system.
- Enabling local performance monitoring to ensure local circumstances are managed in a way to improve efficiency and effectiveness of the system
- Creating a funding stream that can be channelled through the health and wellbeing board to support the shift from acute to prevention in the system
- Enabling a procurement system that works for our rural local economy.

Call for Evidence: North Yorkshire

The Government has introduced reforms to enable council Health & Wellbeing Boards to coordinate arrangements across the council area. At the same time new arrangements have been put in place to provide for Clinical Commissioning Groups, made up of GP's, to commission local health services. These arrangements are welcome but do not go far enough to ensure that councils and GP's who collectively have the best understanding of local communities work effectively together in a combined partnership. North Yorkshire Call for evidence indicated that the devolution of health commissioning should explore the following areas;

- Formal partnership arrangements for GPs and upper tier councils to share the commissioning of all health and social care services.
- Where a County area comprises one or more CCGs, there should be a requirement for CCG boundaries to be co-terminus with the County Council as the lead agency for public health and social care.
- Provide the freedom and flexibility for local authorities to employ health professionals and to deliver a range of health services where appropriate to the area. In some areas, some community services will be best delivered by GPs and local authorities working together. Local authorities have the infrastructure to employ health staff in such a circumstance but are currently limited in doing so by outdated and antiquated legislation.

Call for Evidence: Hampshire

Hampshire want to deliver simple, 'joined-up', integrated health and social care, supporting residents to stay in their own homes for longer, with unrivalled access to innovative care and technologies. Hampshire and their partners are proposing they pilot the integration of data sets from across the NHS and other care services to support this, building on progress already made through the Hampshire Health Record. As part of devolved health and social care arrangements, they are asking that Government devolve control and funding of IT so that CCGs, hospitals, GP surgeries, councils and community providers can make better use of combined investment. This will enable closer alignment of systems and compatibility between data from different care settings.

Beyond this, the County Council, with its partners, is in a unique position to realise long term sustainable efficiencies from the health and social care market, which is worth in excess of £2bn per annum in Greater Hampshire. Hampshire currently works with 5 acute providers and 5 CCGs and brings the scale and competence to commissioning and provision that is unique in England. The Council believes that the development of "out of hospital" community based models will become a pre-requisite to allow for the devolution of health services to Local Government. The County Council's partnership with its CCGs, and different but specific arrangements with the acute sector, would open up opportunities for community services consistent with low cost, high value health and social care provision.

Devolution Proposals

The development of devolved health commissioning arrangements between health and local government **is an essential part** of an English Devolution Settlement between Whitehall and County areas.

Although there remains a lack of detail, the principles of a devolution settlement for counties would continue to build on the direction of travel set by the Greater Manchester Deal and explore the full range of devolved budgets, freedoms and flexibilities to be granted to Greater Manchester. The County APPG's analysis of social care provision in counties, and its call for Health & Social Care Deals', should be adopted as the baseline for the devolution discussion in county areas.

As with other parts of our devolution settlement for counties, there should not be a one-size-fits all approach in achieving this devolution. Our counties with their unique demand pressures and health economies require specific devolution proposals across health and social care.

Following the Manchester Deal, the Department of Health should make a bold statement on its commitment to devolution *across the whole of England*, by establishing a dedicated **Devolution Unit** to explore how individual deals would operate and the role of health and social care in a wider English devolution settlement. This unit could potentially be a joint-venture between DoH, LGA, ADASS and NHS England, with cross departmental collaboration with the Cities & Local Growth Unit, DCLG Public Sector Transformation Unit and Treasury.

The Devolution Unit, and local partners, should explore a range of *devolution by default and legislative* proposals to enable a more localised approach to health and social care integration in county areas, including;

1. Devolved budgets & performance management

The starting point for devolved health and social care arrangements will be delivering a sustainable, fair and integrated approach to budgeting, alongside a proportionate, transparent and accountable delivery framework.

The County APPG inquiry found that a lack of upfront new funding, alongside limited committed resources, shorter financial settlements for social care, and the centrally imposed performance management were key barriers to integration through the BCF.⁶

Evidence to the County APPG showed that the current approach to integrated budgeting has rapidly become a very bureaucratic operation with conflicting incentives and priorities, particularly in two-tier county areas. Not only is the centrally dictated performance management framework highly bureaucratic, it fails to financially incentivise and reward local partners who invest in prevention and new innovations, placing a disproportionate financial risk on local authorities.

The bureaucratic nature of the BCF is a symptom of a wider more fundamental problem: the centralisation of the health service. It is subject to far more prescriptive national guidance, legislation and the whims of national politics. The majority of the money spent locally resides within the NHS, with efficiency savings secured from integration disproportionately benefiting health. To compound matters, health spend is nationally ring-fenced whilst social care has witnessed significant reductions.

A National Health Service free at the point of use clearly requires Parliament and Whitehall to have a wide-ranging and important role in the funding, oversight and delivery of services. CCN

believe that integrated health and social care does not require full *organisational and structural* integration.

However, as the County APPG concluded, whilst central government has a role in setting national standards, integration of service delivery and commissioning will look different from one area to another.⁷

Alongside a sustainable social care funding settlement and wide-ranging NHS tariff reform, *larger or entire* devolved budgets to councils and their local partners must financially incentivise integration; provide up-front funding to pump prime investment in community services; and deliver greater long-term certainty across both health and social care.

Whilst we welcome the Government's recent consultation on removing restrictions on pooled budgets,⁸ the plan to devolve the entire £6bn health budget in Manchester has set a benchmark in which ambitious counties should not fall short of. As part of new devolved health commissioning arrangements, the Devolution Unit and local partners should consider;

- **Extending but reforming nationally led pooled budgeting for those councils who choose to continue working in this way. A pooled health and social care fund of at least £7.8bn should be established by 2019/20.**
- **Freedom to opt out of any continuation of the BCF, agreeing a larger or entire locally pooled budget as part of a Health & Social Care Deal, or wider devolution package, supported by the removal of all restrictions on pooled budgeting and a ten year shared financial settlement for health and social care.**
- **Local partners are given greater freedom to agree robust, transparent and accountable performance management frameworks at a local level with DoH, CLG and NHS England in line with a new shared outcome framework for health and social care.**

2. Enhanced commissioning and financial powers for Health and Wellbeing Boards

Without enhanced powers for local partners to utilise devolved budgets little can be achieved through devolution. Local HWBs and local councils simply do not have the legal authority to make the fundamental changes that may be required. It's time to start getting honest about the structural weaknesses in our health and social care system.

We need to develop new commissioning frameworks to promote collaborative working between health, social care and wider partners. Current arrangements for commissioning primary, secondary and public health services are overly complex and fragmented.

In the case of CCGs they are often too small to deliver economies of scale and are not always fully effective as singular commissioning bodies.

Recent innovations on outcomes based commissioning such as alliance contracting have clearly built on the importance of collaboration, but there are practical constraints on NHS procurement, patient choice and competition regulations. Questions remain over GP capacity to secure necessary back-office efficiencies and deliver asset management rationalisation at the same time as focusing on their primary objective of delivering excellent quality care to local communities.

Local authorities in two-tier areas also add to

the complexity in health provision. Districts provide a range of key preventive services such as housing and Disabled Facilities Grants (DFGs), planning and leisure that delay the development of long-term conditions and promote independence.

DFGs and housing services are particularly significant, and greater co-ordination is needed between tiers. On the former, a study by Astral Advisory for the District Councils' Network argued that DFGs are important to local integration but the 'system of delivery is not working well' in two-tier areas and needed major reform.⁹ This is a situation that the County APPG inquiry suggested had been further complicated by the BCF.¹⁰

HWBs, the locus for bringing these disparate commissioners and services together at a local level, currently lack the power, resources and mandate to drive change across local health economies. Moreover, while local authorities have the infrastructure to employ health staff they are currently limited in doing so by outdated and antiquated legislation.

Where it is desired locally, combining CCG commissioning with social care and public health services through HWBs should deliver improved outcomes through integrated, financially sustainable, joined-up services that are visibly accountable at a local level. Moreover, district and county councils should be encouraged, empowered and incentivised to join-up and pool services at the most appropriate level. Government and local partners should consider;

- **Enabling HWBs to commission primary, secondary health and social care services. Powers to scrutinise and align commissioning plans of CCGs should also be strengthened. HWBs who take on these new powers should be delegated budgetary responsibilities.**

- **Providing the freedom and flexibility for local authorities to employ health professionals and to deliver a range of health services where appropriate to the area.**
- **Local authority partners consider the pooling or delegation of specific housing and health related services, such as DFGs, to the most appropriate strategic level.**

3. Empowered leadership, reformed governance and direct democratic accountability

Underpinning any devolution settlement must be a commitment to robust and accountable governance structures at a local level. The footprint of health economies and their boundaries must also be logical, reducing complexity and promoting collaboration.

The majority of health services provided within a locality are currently not subject to local democratic oversight. The Kings Fund conclusion that there is a 'vacuum' of accountability and local leadership in local health services is evidence of the need for reform. Part of the solution is injecting stronger democratic oversight, challenge and accountability over local health services.

Arrangements for stronger governance and accountability will need to be agreed locally by those local authorities and CCGs consenting to be involved, but these should be based upon a development of HWBs.

Reforms should be undertaken at a national level that strengthen leadership across local health providers, but also challenge HWBs to review their membership and demonstrate their readiness and effectiveness.

This will partly be achieved through greater powers for HWBs incentivising collaboration of local providers, such as acute trusts. However, upper-tier councils have a responsibility of system leadership and should be granted additional powers to ensure partners collaborate.

If partners are to be incentivised to fully integrate services through HWBs, consideration should be given to allowing boards to become independent commissioning bodies in their own right, rather than a statutory council committee. This could engender greater equality between health and social care partners and joint ownership and provide a direct line of accountability.

Part of strengthening local governance and accountability will be significantly reducing complexity within local health arrangements. Much of the complexity in local health economies in county areas stems from multiple CCGs, which in many cases overlap between different local authority boundaries. Ensuring a devolved system of health and social care delivers more efficient and effective services will require a rationalisation of organisations and boundaries.

Consideration must also be given to how health economies and any new local arrangements interact with wider governance arrangements, such as Combined Authorities. Health economies are not the same as functional economic areas, but there will be wider benefits to ensuring that the administrative boundaries of health providers collaborate with, and potentially join, wider governance arrangements.

The precedent seen in Greater Manchester of a directly Elected Mayor should not be regarded as a prerequisite for the devolution of a larger or entirely pooled health budget across a locality of partners, including pan-county arrangements or sub-county region. However, in line with the wider Governance proposals outlined in this County Devolution document, authorities

must consider forming strong accountability mechanisms, aided by Government legislation where needed.

Achieving the above will require action at both a local and national level, including;

- **HWB governance is revised to allow the establishment Boards as an independent commissioning bodies in their own right.**
- **Local authorities conduct a full review of their membership of HWBs, ensuring sufficient representation from the full range of partners, particularly acute trusts.**
- **To achieve visible, strong leadership, Council Leaders should be the default Chairman of Boards that adopt additional powers and budgetary responsibilities.**
- **Local partners are given freedom to review and rationalise CCGs and their boundaries, seeking coterminosity with local authority boundaries where possible.**
- **Partners are given greater freedom and flexibility to explore how HWBs interact within wider governance arrangements, including Combined Authorities, with Government reforming legislation where necessary.**

REFERENCES

¹ LGA (2015) *The funding gap for councils in England between March 2014 and the end of 2015/16 will be £5.8 billion.* at: <http://www.local.gov.uk/finance/>

² NHS England. *NHS Five Year Forward View (2015)*, p. 17

³ National Audit Office. *Managing the transition to the reformed health system (2013)*
& <http://www.hsj.co.uk/home/commissioning/can-councils-have-a-role-in-commissioning-support/5067929.article#.VOuBYnysXvV>

⁴ *The Kinds Fund. The Coalitions Reforms Part 1: Health (2015)*

⁵ County APPG. *The State of Care in Counties (2015)*

⁶ County APPG. *The State of Care in Counties (2015)*

⁷ County APPG. *The State of Care in Counties (2015)*

⁸ DoH Consultation 2015

⁹ Astral Advisory, 2013

¹⁰ County APPG. *The State of Care in Counties (2015)*

INFOGRAPHICS

^I County APPG. *The State of Care in Counties (2015)*

^{II} Capita & CCN. *Transforming Adult Social Care Survey (2015)*

^{III} County APPG. *The State of Care in Counties (2015)*

^{IV} Capita & CCN. *Transforming Adult Social Care Survey (2015)*

^V County APPG. *The State of Care in Counties (2015)*

^{VI} County APPG. *The State of Care in Counties (2015)*

^{VII} County APPG. *The State of Care in Counties (2015)*

CCN

COUNTY COUNCILS NETWORK

Founded in 1997, the County Councils Network (CCN) is a network of 37 County Councils and Unitary authorities that serve county areas. We are a cross-party organisation, expressing the views of member councils to the wider local government association and to Central Government departments.

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