West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 6th October 2020		Agenda item: 91/20	
Report title:	**Developing Commissioning Futures**		
Joint Committee sponsor:	Jo Webster		
Clinical Lead:	N/A		
Author:	Esther Ashman, Programme Director		
Presenter:	Esther Ashman, Programme Director		
Purpose of report: (why is this being brought to the Committee?)			
Decision		Comment	✓
Assurance	✓		

Executive summary

1. This paper provides an update on the development journey of Commissioning Futures, the potential impact of the current legislative discussions nationally and an opportunity for Joint Committee to consider the future of commissioning in this context.

2. The paper sets out the strategic context to the work, highlighting the national discussions around the future of commissioning and Integrated Care systems under the six themes of: place; provider collaboration; leadership & governance; commissioning; financial framework and data/intelligence/analysis. It sets out the need for West Yorkshire to be able to articulate a strong narrative around the right commissioning model for our populations.

3. Following on from previous discussions at Committee, a partnership framework for Commissioning in West Yorkshire has now been developed with a clear narrative to articulate our approach. The paper sets out this narrative, outlining our West Yorkshire model built on the uniqueness of our places.

4. The paper also sets out the current development of an operating model for commissioning in West Yorkshire which describes our approach as a partnership, with a particular emphasis on the narrative for commissioning at place. This operating model will come to a future meeting of the committee for comment and approval.

Recommendations and next steps

Joint Committee are asked to:

1. Note the update on the Commissioning Futures programme and to comment on and agree the proposed next steps in developing the operating model.

2. Note and discuss the current legislative context and what this may mean for the future of commissioning.

Delivering outcomes: describe how the report supports the delivery of STP outcomes (Health and wellbeing, care and quality, finance and efficiency)	
Delivering the 10 ambitions of the West Yorkshire & Harrogate Health and Care Partnership is at the heart of the development of the Commissioning Framework.	
Impact assessment (please provide a brief description, or refer to the main body of the report)	
Clinical outcomes:	Improving clinical outcomes is central to any refined commissioning processes.
Public involvement:	As above.
Finance:	N/A.
Risk:	The risks to delivery of the Commissioning Futures programme are currently in draft form and will be reported to the next meeting in public
Conflicts of interest:	None identified at this point.

Joint Committee of Clinical Commissioning Groups

6th October 2020

Developing Commissioning Futures

Purpose

1. This paper provides an update on the development journey of Commissioning Futures and the potential impact of the current legislative discussions nationally.

Background/Strategic Context

2. Commissioning and the wider functions of Integrated Care Systems (ICS) are under much discussion nationally following initial proposals highlighted in the NHS Long Term Plan. There is already national commitment to all systems becoming ICS's by April 2021 and we are expecting further NHSE/I guidance shortly to support ICS development. This guidance will be set in the context of the 2012 Health and Social Care Act however, it is anticipated that there will be proposals to make wider changes to this next year. It is important to note however, that there is a significant variation in the size and maturity of ICS's nationally therefore there cannot be one approach which will be right for all. We know that this guidance will be set around the six themes of: Place; Provider Collaboration; Leadership & Governance; Commissioning; financial framework and data/intelligence/analysis and there are a number of representatives from West Yorkshire and Harrogate involved in the development of these themes.

3. ICS's are already evolving and the two roles they are now starting to take are on system transformation (delivering a co-ordinated programme of transformational change, to secure the long-term sustainability of the system, ensure local delivery of the LTP and delivery of plans agreed collectively for the population) and management of system performance (working across ICS partners to improve operational performance of the system and hold each other to account). For West Yorkshire & Harrogate we have a long history of this, with a partnership approach to bringing leaders across sectors to have a shared responsibility for health and care for our populations.

4. With these national developments in mind, it is critical that we are able to articulate a narrative for how we wish to commission in West Yorkshire. Building on our model of subsidiarity our commissioning development programme has an approach to commissioning of doing what is right for our places and our populations, only commissioning at ICS level where we cannot do it at place, only commissioning in place where we cannot do it in communities and only commissioning in communities where individuals can't do things for themselves. Our vision is that commissioning is everyone's role and that reducing health inequalities is embedded at the heart of all commissioning.

5. Commissioning as a function is changing and our commissioning development programme is embracing this change and has an ambition to deliver differently in this context. To deliver this ambition we know our CCG's will need to move to having a single strategic commissioning approach with Local Authorities, using a population health management approach to ensure effective planning and delivery of care for all ages and a 'Health in all Policies' approach. This will encompass not just social care but also public health jointly working with the CCG's as commissioners together, sharing (and making the most of opportunities) to share resources and where appropriate, pooling budgets.

6. Our ambition is to align leadership capacity. Working together as a single leadership teams across NHS, Social Care and Public Health with joint appointments and pooled resources in order to ensure effective strategic commissioning. We want to be able to lead on behalf of each other, both across our local systems but also at West Yorkshire & Harrogate level.

7. Our commissioners and providers will work together in our places to plan and deliver services through their established or developing partnerships moving to models which have a greater emphasis on whole population health outcomes. This way of working through our place based commissioner/provider partnership arrangements will facilitate our local systems to carry out pathway redesign, service development, medicines optimisation, and workforce development in order improve the health of our populations and reduce health inequalities.

8. Working in this way through commissioner/provider partnerships enables our local systems to take a population health management approach in exploring collaboration opportunities, working together to standardise practice, share resources or redistribute services through the integration of commissioning and provision.

9. Our programme of commissioning signals a move from commissioning from a predominantly health care focus to one of population health being planned and delivered from a system not organisational focus. Our CCG's will build on their role as population planners alongside Local Authorities and all partners in the NHS, Social Care and Public Health will need to evolve in order to come together to commission and provide services through new collaborative alliance models of provision. We will also work in partnership to tackle the wider determinants of health through this model, working with the regional Economic Recovery Board to consider the best ways to both protect and build the economy whilst being conversant of the importance of good health and the health and care economy. This relationship enables us to also work together to identify opportunities for working differently in the context of devolution.

10. We've already made significant progress in this work with good examples across the ICS of how we are already working in this way, such as in the 'Act as One' approach in Bradford and the Mental Health Alliance in Wakefield. We have also made great progress in how we commission across West Yorkshire through our Joint Committee acting as our collaborative decision making forum. Our Joint Committee is a well established mature decision making collaborative with a diverse membership which reflects our populations. It has a strong track record of making decisions for our populations and continues to develop and evolve to ensure that it will continue to do so. Our recent Cardiovascular Initiative of the Year award for our Healthy Hearts programme is an excellent example of where we have worked collaboratively to commission to a common set of standards and outcomes and in turn significantly improved population health in this area.

11. Our work also takes in to account the role of the partnership in specialised commissioning and how we can work more closely together. Our Mental Health, Learning Disabilities and Autism Programme Board is a good example of where commissioners and providers come together including NHSE/I, to remove barriers to integration and ultimately ensure that our resident population receive the best care and support that can be offered within finite resources. We hope to also take this approach to exploring this way of working with NHSE/I in other areas such as acute care.

Commissioning at place

12. Our places are diverse, each with its' own history and we want to take an approach that is tailored to reflect this diversity. We are building therefore, a West Yorkshire model which is built on the uniqueness of our places. We know that the impact of COVID on our populations will be significant, especially for those populations experiencing the most inequality. We know that some of the impacts these populations will experience will only be able to be mitigated through working in partnership, enacting our partnership values and behaviours and having a focus on health outcomes and inequalities in all our commissioning. In order to tackle this we aim to plan on a long-term basis through embedding a preventative approach to our strategic commissioning.

13. Each of our places already has a shared vision and partnership arrangements in place, set under the governance of the Health and Wellbeing Board. Our ambition however, is to move beyond this to build a shared ethos and consensus in our local systems, to create a 'one team' approach to working which brings together NHS, Social Care and Public Health across all health and care services, adopting a principle of "health in all Services" approach in children's, adults and other services relating to the wider determinants of health.

14. We will still be commissioning the services our population needs however, the way in which we do it will change to have a system focus and in future will work together to make shared decisions. This will place more prominence on our commissioner provider partnerships which make shared decisions to improve population health. We believe that this work should happen as close to the individual as possible to make the most impact therefore, the development of our local community partnerships and primary care networks will be key to delivering real outcomes for our populations. Our CCG's have and will continue to take a system integration role in developing these local partnerships, a role that has proved very successful during our response to COVID in West Yorkshire.

Our Commissioning Framework

15. Our emerging model for commissioning sets a framework through which commissioning will take place in broadly three pillars:

    - Commissioning which happens in each place, tailored to local population need and focussed on improving population health, developed and delivered collaboratively as a system in that place.
    - Commissioning which is developed once collaboratively in partnership across the ICS footprint, tailored to population need with a focus on improving population health, but delivered separately in each place to a common specification/set of outcomes and standards defined at the ICS level.
    - Commissioning which is developed and delivered once in partnership across the WY&H footprint tailored to the cohort of the population and with an improving population health focus.

16. Our places remain central to this model and they will continue to evolve as they move towards a system by default approach at place. We will move away from a model of traditional commissioning to a model where we work together as partners across our place to deliver more integrated care for our population, support a greater focus on prevention and the wider determinants of health, support our populations to be empowered to manage their own health and wellbeing and to enable health and care needs to be addressed around local neighbourhoods.

17. As part of our model we are also developing a set of financial principles to support our commissioning work in future, which will set out to do the following:

    - Financial risk share to help us individually manage high risk fluctuations.
    - Agreed financial management arrangements in order to enable us to do things together
    - Agreed financial management arrangements to support the development of commissioning futures.

Next Steps

18. Our developing framework whilst led by the CCG's, has been co-designed in partnership across the ICS and is currently going through an extensive engagement exercise in order to have a true partnership approach to commissioning which is co-owned by the partnership. We will continue this journey of development as we use our framework to identify which areas of commissioning will bring about an added value for our populations by developing and delivering collaboratively at an ICS level.

19. Our operating model for commissioning will set this work out and will be agreed by the Health and Care Partnership in the coming months. Working closely with programme leads across the ICS the model will describe the added value of working collaboratively at an ICS level in some of the areas agreed in the JCC workplan including, cancer, maternity services, urgent and emergency care, mental health and planned care. As part of this work we will continue to co-design the detail of the model with leads from all sectors in order to ensure that we have a co-designed, co-owned model for commissioning for our partnership.

Recommendations

20. Joint Committee are asked to note the update on the Commissioning Futures programme and to comment on and agree the proposed next steps in developing the operating model.

21. Joint Committee are asked to note and discuss the current legislative context and what this may mean for the future of commissioning.

Jo Webster – SRO Commissioning Futures

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