Department of Health

Government Response to the House of Commons Health Select Committee Report into Long-Term Conditions

(Second Report of Session 2014-15)

Cm 8937

Government Response to the House of Commons Health Select Committee Report into Long-Term Conditions

(Second Report of Session 2014-15)

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

September 2014

Cm 8937

This publication is available at www.gov.uk/government/publications

Any enquiries regarding this publication should be sent to us at Department of Health, 79 Whitehall, SW1A 2NS

Print ISBN 9781474110693
Web ISBN 9781474110709

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

ID 2902798 09/14 43105 19585

Printed on paper containing 75% recycled fibre content minimum

Contents

Introduction

The Government welcomes the Health Select Committee's investigation into the management of long-term conditions (LTCs) in the NHS. We are in agreement with many of the Committee's recommendations and have welcomed the scrutiny they have brought to the role of Government, the NHS and wider health and social care organisations as we work collectively to change the way LTCs are managed and to enhance the quality of life for everyone with an LTC, their carers and their families.

We have been open and transparent about the challenges this country faces in meeting the needs of growing numbers of people living with an LTC, amongst whom multimorbidity is fast becoming the norm. In addition to this, the growing pressures on our Accident and Emergency (A&E) Departments, some of which we know is brought about by patients whose care has not been managed as well as it could have been in the community, needs to be tackled.

More needs to be done to ensure everyone with an LTC is supported and empowered to live healthily, independently and in control of their care. Through the Mandate, we have asked NHS England to work to achieve this, and in response, it is striving to implement a whole system framework for LTCs, implementing the House of Care Model across the NHS. The model is designed to support the delivery of person-centred, coordinated care, which enables individuals to make informed decisions which are right for them, and empower them to self-care in partnership with health and care professionals.

We have also asked NHS England to do more to ensure better integration of health and care services, and there are currently a range of initiatives underway designed to achieve this. NHS England and the Department of Health are the key partners on the National Collaboration for Integrated Care and Support (NCICS), which has set out the first system-wide shared commitment to support local areas in delivering integrated care. The NCICS has lead the establishment of 14 integration pioneers to address barriers to delivering integrated care and support locally, and to highlight barriers that exist nationally that integration partners can work to address.

In addition to this, the £3.8 billion Better Care Fund will provide the largest ever financial incentive for the NHS and local government to work together. The fund will help shift resources from the acute sector by tackling expensive pressure points in the system like A&E, providing greater investment in improving prevention services, reducing unplanned hospital admissions and by helping people to stay in their homes and live independently. The fund mandates local areas, through their Health and Wellbeing Boards, to agree the joint use of £3.8 billion for this purpose in 2015-16.

Government response to the Committee's conclusions and recommendations

STRATEGIC DIRECTION OF SERVICES FOR LONG-TERM CONDITIONS

Integrated care pioneers

We note with interest the establishment of 14 pioneer sites which are intended to address existing barriers to the integration of health and care services and indicate where such barriers need to be broken down by work at national level. We plan to examine the work of these integration pioneers in greater detail in a separate inquiry. (Paragraph 21)

We welcome the commitment of the National Collaboration for Integrated Care and Support to ensuring that all localities in England have adopted models to commission and deliver integrated care and support by mid-2015. We recommend that the Department of Health monitor progress towards the achievement of this objective and publish by July 2015 its assessment of the extent to which each locality in England has adopted models to commission and deliver integrated care and support, together with its assessment of the strengths and weaknesses of different models and approaches in particular contexts. (Paragraph 22)

1. Through the NCICS the Department of Health, in partnership with 13 other organisations, provided the framework document on integration, *Our Shared Commitment*, to help local services bring together health and social care organisations to provide integrated care services. The NCICS said it would judge itself successful if all localities in England had adopted models for integrated care and support by mid-2015 and, going forward, will consider how such an assessment might be appropriately made.

2. In *Our Shared Commitment*, the integrated care pioneers programme was also announced and 14 pioneering local areas were subsequently selected to act as exemplars, demonstrating new, innovative ways of delivering coordinated care. To evaluate and support the spread of learning from the programme, the Department has commissioned the Policy Innovation Research Unit at the London School of Hygiene and Tropical Medicine to carry out an independent early evaluation in the context of the Better Care Fund (BCF). The final report on the evaluation is due to be submitted to the Department in summer 2015.

3. In addition, to follow on from the early evaluation described above, we are seeking to commission a longer-term independent evaluation of the pioneers programme in the context of new funding arrangements for integrated care in England. Subject to feasibility, this would comprise three components: process; outcomes; and economic evaluation.

Progress against the Mandate and NHS outcomes framework

We note the claims made by the Department of Health and NHS England for progress against the objectives set out in the Mandate. We are nevertheless not persuaded that the claims made to us represent substantive progress against the measurable objectives given to NHS England, such as they are. The publication of a resource to assist service users in personalising their services is not in itself evidence of progress in their experience of care or improvement in their quality of life. (Paragraph 30)

The intention in the Mandate and the NHS Outcomes Framework to establish measures to indicate progress in the enhancement of quality of life for people with long-term conditions is welcome. We nevertheless note that a number of these indicators are still in development or have been introduced so recently that they cannot demonstrate in any meaningful sense what progress may have been made by the NHS in increasing the quality of life for people with long-term conditions by March 2015. We recommend that in its response to this report the Department of Health should quantify the "measurable progress" it expects NHS England to have achieved against clearly specified baseline measures for all relevant Mandate objectives for long-term conditions. NHS England should similarly set out in response to this report the progress it has made against each objective against the same baseline measures together with its estimate of likely further progress by March 2015. Where such indicators and baselines are not yet available the Department should be transparent about the extent to which measurable objectives can be said to exist and consider how those objectives should be developed and modified. (Paragraph 31)

4. The Mandate to NHS England sets out the Government's ambitions for the NHS and it is intended to be strategic and outcomes focussed, comprising a series of objectives underpinned by the NHS Outcomes Framework. Progress against delivering the Mandate is measured as part of the formal accountability arrangements, through the NHS England Annual Report and the Department's annual assessment. Both of these, relating to 2013-14, were laid before Parliament on 22 July 2014.

5. One of the Mandate objectives for NHS England is to demonstrate progress against the five domains and all of the outcome indicators in the Outcomes Framework – including, where possible, by comparing services and outcomes with the best in the world. Metrics in the NHS Outcomes Framework relevant to LTCs include: Health related quality of life for people with long-term conditions; Proportion of people feeling supported to manage their condition; and Employment of people with long-term conditions. These three metrics all have data relevant to 2013-14, the year NHS England was established and the year of the first Mandate. Data from the NHS Outcomes Framework is one source of information used to inform the Department's annual assessment and contribute to an overall picture of progress.

6. NHS England's Annual Report outlines some of the achievements already made against these objectives during 2013-14 and NHS England's 2014-15 Business Plan sets out further steps it intends to take in striving to meet them. Our annual assessment, NHS England's Annual Report and Business Plan, *Putting Patients First 2014-15 – 2015-16*, are all published and freely available.

A cross Government strategy

We note that the original plan to develop a national strategy for long-term conditions was explicitly cross-government in its perspective and involved participants from 12 Government departments. This attempt to develop a joined-up, government-wide approach to the management of long-term conditions has been dropped following the transfer of policy responsibility from the Department of Health to NHS England. The Department and NHS England should clarify how cross-departmental working is to be continued in the absence of a cross-Government strategy. (Paragraph 41)

7. We remain committed to working across Government and with external partners to ensure that strategies and initiatives to promote improved care and outcomes for people with LTCs are reflected in Government policies generally. Representatives from other Government departments and agencies are closely involved in various programmes of work NHS England is undertaking that have both a direct and indirect impact on enhancing the quality of life for people with LTCs. Going forward, in partnership with NHS England, we will explore whether further systems and structures are required to support cross-Government and cross-organisational working.

A strategic response to tackle long-term conditions

We are concerned that the growth in demand arising from long-term conditions and associated patterns of co-morbidity has not been matched by the urgency with which the Department of Health and NHS England have developed their strategic responses. This finding is of particular concern since the long-term conditions agenda lay at the heart of the Nicholson Challenge to achieve transformative change in the delivery of health and care services. We recommend that in its response to this report NHS England set out clearly:

- ***the changes it considers necessary to better support people with long-term conditions;***
- ***the strategic objectives such changes are meant to fulfil;***
- ***the plan it has devised for achieving such changes;***
- ***the steps to be taken to engage other relevant Government departments in the delivery of such changes, and***
- ***the milestones it has set for delivery. (Paragraph 42)***

8. Through the Mandate, we have set out a strategic objective for NHS England to make measurable progress towards making our health service among the best in Europe at supporting people with ongoing health problems to live healthily and independently, with much better control over the care they receive. Alongside this, we have set out key objectives for NHS England to achieve which we believe will transform the way care is provided and the way in which people with LTCs are supported and empowered to manage their condition.

9. NHS England's strategic approach has been to set out and implement a whole system framework for LTCs to deliver proactive, person-centred, coordinated care, especially for those most at risk and with complex care needs. Each component of the LTC framework contains deliverables and timetables for their completion, including the implementation of the House of Care (HOC), and these are set out in the NHS England Business plan, *Putting Patients First 2014-15–2015-16*. These will contribute to

supporting the whole system change required to transform the care of people with LTCs.

10. Examples of key pieces of work contributing to the implementation of the framework are covered in our response to the Committee's report, such as: the integrated care pioneers; the Year of Care commissioning model; the Better Care Fund; the proactive care programme; commissioning for value packs; the LTC web-based toolkit and dashboard; the patient activation measure; and, the Task and Finish Group, which is developing best practice guidance on personalised care and support planning. Other action underway includes:

- citizen participation and empowerment – further roll out of the summary care record to ensure essential information is available at the point of care;
- General Practice and community based care – the *Improving General Practice – phase one report* sets out ambitions for General Practice and out-of-hours care;
- parity of esteem for mental health – several workstreams under the parity of esteem programme will contribute towards the quality of care for people with LTCs including the dementia diagnosis ambition, improving access to psychological therapies and improving the quality of crisis care for people with mental health problems;
- learning disabilities and special educational needs and disability – the Learning Disability Premature Mortality Review Body will inform the requirement for reasonable adjustments in the provision of healthcare for this group and improve health outcomes; and
- medicines – the medicines optimisation dashboard demonstrates to Clinical Commissioning Groups (CCGs) and providers how to help their patients get more from their medicines; work will continue with the *Community Pharmacy Call to Action* response to ensure pharmacists, GPs and patients work together to manage LTCs.

11. In addition, the integrated personal commissioning programme, announced by NHS England in July 2014, aims to demonstrate how the NHS and social care can work with individuals and communities to deliver person-centred care and integration at the level of the individual. Starting in April 2015, the programme is aimed at key groups including people with multiple LTCs (particularly older people with frailty), people with learning disabilities with high support needs, users of mental health services and children with complex needs. It will allow funding to be pooled across local authorities, CCGs and specialised commissioning, and will explore how individuals can have more control over how this funding is used through personalised care and support planning, individualised commissioning and personal health budgets.

The Mandate refresh

The Secretary of State should publish, as part of his response to this report, a statement of the changes the Government would wish to see incorporated into the next refresh of the Mandate in respect of long-term conditions, including a statement of the urgency he attaches to their delivery. (Paragraph 43)

12. On 22 July 2014, the Secretary of State announced that the Government proposed to uphold all of the objectives in the current Mandate and make no changes for 2015-16. A stable Mandate will enable the NHS to build on its achievements and make further progress on the ambitious agenda already set. We have been working closely with NHS England on this approach to the Mandate

and are engaging with stakeholders ahead of its publication this autumn.

Reporting on the impact of clinical commissioning groups plans on local health economies

We further recommend that NHS England report to the House by October 2014 at the latest on the outcome of its 2014 planning round, setting out in detail its assessment of the aggregate effect on the health economy of England and of each NHS England area of the local plans made by each clinical commissioning group. (Paragraph 44)

13. All operational and strategic plans, which covered operational plans for 2014-15 and strategic plans for the period 2014-15 to 2018-19, have now been received by NHS England. These are undergoing a process of triangulation involving Monitor, the NHS Trust Development Authority and local government, where appropriate, to reconcile any issues where commissioners and providers have developed plans with different assumptions. For the first time, commissioners have been asked to plan on a five-year trajectory, to enable the NHS to capitalise on opportunities for transformational change and improvement. All 211 CCGs, together with their NHS England Area Teams, are being asked jointly to set levels of ambition against seven overarching outcomes. NHS England will be looking at all the local ambitions, and supporting commissioners to work with their providers to achieve those outcomes.

14. Each plan will be focused on supporting local needs and will therefore be constituted differently with different intended impacts. That being the case, aggregation to area or national level would be difficult and unlikely to result in meaningful information. Nonetheless, the strategic plans are being reviewed by NHS England and partners in order to inform the development of the NHS five year forward view, due to be published in the autumn. Drawing on the plans to identify emerging themes in these areas will ensure that the national system supports and enhances the innovative approaches being developed across the country.

CLINICAL CARE FOR PEOPLE WITH LONG-TERM CONDITIONS

National Institute for Health and Care Excellence guidance

We recommend that in revising its present clinical guidelines and developing further guidelines the National Institute for Health and Care Excellence should routinely take into account the incidence of multiple morbidities and the attendant risks of polypharmacy. (Paragraph 57)

15. The National Institute for Health and Care Excellence (NICE) is currently in the early stages of developing a new clinical guideline which will look at the assessment, prioritisation and management of care for people with commonly occurring multiple morbidities. It is anticipated that this new guideline will be used in conjunction with condition-specific guidelines to help with decision making for those with complex health problems, and so avoid unhelpful polypharmacy.

Revising the definition of a long-term condition

The objective of the health and care system in treating people with long-term conditions should be to improve the quality of life of the person. At a time when increasing numbers of people requiring support and treatment from the system have multiple conditions combining physical health, mental health, social care and other support

requirements, it seems anachronistic that the Department's definition of long-term conditions appears to emphasise a single-disease approach to treatment. We recommend that the Department revise its working definition of long-term conditions to emphasise the policy objective of treating the person, not the condition, and of treating the person with multiple conditions as a whole. (Paragraph 59)

16. The Government agrees that the definition of an LTC should reflect the need to treat the whole person and not just a set of symptoms. Whilst there is no single definition of an LTC in use in the Department of Health, definitions of LTCs used by the Department in the past were narrower. Today we and our partners firmly support a holistic, person-centred approach to LTC care and definitions that reflect this. The following definition used by NHS England is a good example:

> *"People living with LTCs cannot, at present, be cured, however, a person-centred approach that delivers the right care no matter what the condition(s) through person-centred care planning ensures that people can be involved in managing their conditions, receive the care they need to live and die well and that both they and their carers feel supported to maintain a good quality of life."*

The re-balancing of commissioning and care pathways for long-term conditions

The evidence the Committee has taken on diabetes services demonstrates the need for a general rebalancing of commissioning and care pathways for long-term conditions. These should provide treatment which is integrated across primary, community, secondary and social care settings.

17. We recognise that changes to commissioning and care pathways can deliver real improvements in care for people with LTCs, providing greater integration of health and care services, in particular, more cohesive systems of out-of-hospital care. On 1 May 2014, NHS England announced plans to allow CCGs to develop new models for co-commissioning primary care that will support and improve holistic and integrated care commissioning in line with the complex needs of people with LTCs. CCGs were asked to submit expressions of interest to NHS England by 20 June 2014, and 196 CCGs responded. The first tranche of new co-commissioning schemes are likely to be announced in autumn 2014.

18. In addition to this, NHS England's commissioning for value programme produces information packs for CCGs to help to improve specific care pathways by providing data, evidence, tools and practical support on spend, outcomes and quality. The pathways cover LTCs such as diabetes, asthma, chronic obstructive pulmonary disease, heart disease and mental health conditions. The packs present information on prevalence, activity, spend, best practice care processes and outcomes to enable commissioners to identify which parts of the pathway might be improved to deliver better services for patients.

The benefits of self-management

We recognise the benefits to the patient and to the health and care system of robust support for self-management of long-term conditions. (Paragraph 80)

19. The Government recognises the benefits to both the patient and to the health and care system of robust support for self-management of LTCs. This is reflected in the Mandate which tasks NHS England with ensuring that the NHS becomes dramatically better at involving patients and their carers,

and empowering them to manage and make decisions about their own care and treatment.

20. NHS England is committed to embedding self-care and support for self-management approaches throughout the NHS. As noted by the Committee, NHS England is using the HOC approach to set out the framework for what needs to happen to make personalised care and support planning a reality for everyone living with an LTC. Support to self-care is a key element of this and, in June this year, NHS England published a web-based toolkit and dashboard to support the implementation of the HOC, including national guidance, evidence and local examples. The dashboard includes the indicator, People feeling supported to self-manage, and provides data at CCG and local authority level. Later this year, NHS England also plans to publish a supported self-management guide for people with complex care needs and frailty, co-produced with patients and carers.

21. Working with the Health Foundation and the King's Fund, NHS England has also put together a learning set of five CCGs and the UK Renal Registry to pilot the use of the Patient Activation Measure (PAM). The PAM is a scale for identifying the knowledge, skill and confidence a patient has in managing their health and care. Using PAM scores for over 150,000 patients with LTCs over the next two years, the pilot will evaluate and spread learning on: measuring PAM in the NHS and the impact activation has on care planning and support for self-management; and build an evidence base for the role of activation in improving outcomes, reducing costs and inequalities.

The role of clinical nurse specialists

We view with concern reports of apparent downgrading of the role of, and reductions in the numbers of, specialist nurses. Their expertise is vital in supporting an integrated system of care for diabetes, from self-management through to acute and specialist services. (Paragraph 81)

22. The Government recognises the vital role of clinical nurse specialists in providing expert care, support and advice to patients, carers and families in the management of LTCs. However, it is for local commissioners and providers to be content that they are providing specialist skill and expertise in the most appropriate and sensitive way for their local populations. Mechanisms such as the Joint Strategic Needs Assessment (JSNAs) have a place in advising and informing this and commissioners should challenge and support their provider organisations to shape their workforce accordingly.

Individual care planning

The purpose of a health and care system designed to manage the care of people with long-term conditions must be to deliver interventions which are as effective as possible in sustaining and prolonging the quality of life of the service user. Moreover, such interventions are unlikely to be restricted to those within the remit of health and social services. We wholeheartedly endorse the principle that systems for the management of long-term conditions must be designed to be responsive to the service user's needs and priorities for their own wellbeing. (Paragraph 93)

We consider that in order to meet its objective of empowering patients fully in their care, NHS England should promote the introduction of individual care planning for service users with long-term conditions. NHS England should adopt and adapt the principles underpinning the House of Care approach as necessary and should seek to eliminate barriers to

effective integrated working. The House of Care model and its associated delivery system provide a sound conceptual framework to analyse and determine an individual's care needs. However, care must be taken to ensure that the wishes and requirements of the service user are not subordinated to rigid and inflexible care planning protocols. (Paragraph 94)

23. NHS England's HOC model takes a whole-system approach to the management of LTCs, putting the person, their requirements and wishes at the centre of care. It is about aligning levers, drivers, evidence and assets to enhance the quality of life for people with LTCs no matter what or how many conditions they have. The integrated personal commissioning programme, announced in July 2014, is another opportunity to explore how to bring together health and social care funding streams and enable people to plan their care based on what makes most sense to them and their family.

24. NHS England has also established a Task and Finish group, which includes commissioners, providers, patient and carer representatives, and policy advisors from across health and social care, to help develop best practice guidance on personalised care and support planning. As its basis, it uses the principles of care and support planning developed by National Voices and it promotes the HOC model as a way of identifying the different considerations and changes that need to be made across the whole system in order to deliver person-centred, coordinated care. The guidance builds on learning from a number of different initiatives including Year of Care, personal health budgets, end of life advanced care planning and work from the integration pioneers. The guidance is due to be completed in autumn 2014. NHS England is also working in partnership with members of the Coalition for Collaborative Care to tackle some of the barriers to achieving its vision for care and support planning.

Complementary medicines

We note that greater involvement of service users in discussions and decisions about treatment of their long-term conditions will inevitably increase the demand for commissioning of complementary and alternative treatments by patients who feel that they have gained benefit from them in managing their conditions or who believe these treatments will be effective. The test for commissioners and health and care professionals will be how to evaluate and measure the effectiveness of such interventions appropriately, and to determine whether they will deliver improved outcomes in terms of better quality of life. (Paragraph 102)

25. Complementary and alternative medicine treatments can, in principle, feature in a range of services offered by local NHS organisations. NHS England agrees there is a need to evaluate the effectiveness of such interventions appropriately and it is for commissioners to ensure any therapy is judged on its efficacy, safety and the contribution it makes to a patient's quality of life.

Use of technology

We recognise the considerable benefits to patients and the health and care system of greater use of electronic records, better information sharing and more supported self-management. The NHS is nevertheless designed as a universal service and its benefits must be accessible to all. Advances which will benefit the engaged, informed and technologically-literate patient must not be pursued to the disadvantage of those who are vulnerable or unable to

access new opportunities for better care. (Paragraph 108)

26. This Government recognises that better use of technology in the NHS can empower patients, improve communication between services and deliver efficiencies and savings for the NHS. Through the Mandate we have asked NHS England to achieve a significant increase in the use of technology to help people manage their health and care, in particular to allow people to: access health records online; book GP appointments online; have consultations online; and benefit from telehealth and telecare to manage LTCs. However, it is important that it is not delivered at the expense of those without access to online services or those with low levels of computer literacy.

27. Over the past 18 months NHS England has run a programme to reach 250,000 people who lack the digital skills to access healthcare data online. The widening digital participation programme is run in connection with the Tinder Foundation, and this year it aims to:

- reach 150,000 citizens with digital skills for health communications;
- train 100,000 citizens in digital skills;
- target populations in socially deprived areas who experience health inequalities;
- develop and implement online training resources;
- carry out a programme of stakeholder engagement including digital inclusion organisations, primary care, and CCGs; and
- establish a network of flagship centres to build good practice case studies and provide local champions.

A long-term conditions workforce for the future

We note with concern the shortfall in the primary care workforce projected by the Centre for Workforce Intelligence. We recommend that Health Education England set out clearly how they plan to address this projected shortfall. (Paragraph 115)

If care planning, integrated services, multidisciplinary working and supported self-management of long-term conditions are to become common practice across the health and care system, the requirement for structural and cultural change at all levels will be extremely challenging. Medical professionals in all disciplines who are treating those with long-term conditions will in many cases have to adapt their ways of working with patients and with those from other disciplines. (Paragraph 116)

We recommend that Health Education England, in response to this report, sets out its strategy for the adaptation of the present medical workforce, and the training of the future workforce, to the delivery of a model of integrated care centred on the person. Such training should also encourage those specialising in one discipline to develop an understanding of the functioning and the capability of other healthcare disciplines and therapies. (Paragraph 117)

28. Through the 2014-15 Mandate to Health Education England (HEE) we have asked HEE to assess the extent to which the existing education, training and ongoing development arrangements enable staff to support self-care and self-management and to ensure that the five million carers looking after friends and family members will routinely have access to information and advice about the support available.

29. In June 2014, HEE published a 15-year strategic framework that focusses on an evidence based understanding of the drivers of change and their influence on people and patients of the future, such as increasing multiple morbidities and complex LTCs. HEE identified the key characteristics of the future NHS workforce, which include:

- the ability to provide informal support that helps people prevent ill health and manage their own care as appropriate;
- the skills, values and behaviours required to deliver co-productive and traditional models of care as appropriate;
- adaptable skills that are responsive to evidence and innovation to enable whole person care, with specialisation driven by patient rather than professional needs; and
- the skills, values, behaviours and support to provide safe, high quality care wherever the patient is and at whatever time of day.

30. HEE is working with partners, including NHS England and Public Health England, as well as third sector organisations and the Royal Colleges, to understand how to shape the workforce of the future. This work includes determining how to support improvements in the general practice and primary care workforce such as:

- improving the recruitment of GPs, practice nurses and other practice staff in communities where this has been challenging;
- promoting safe, effective and proportionate routes for GPs wishing to return to practice;
- supporting the retention of the existing GP workforce;
- supporting the development of community, district and practice nurses through the community nursing strategy programme; and
- encouraging more effective use of skill mix in general practice;
- encouraging practices to make the best use of community assets.

31. HEE is due to report on the current position regarding the training and education of medical staff and any changes that may be needed by October 2014.

MANAGING THE SYSTEM TO DELIVER BETTER CARE FOR LONG-TERM CONDITIONS

Addressing service structures and incentives that send patients to A&E

We doubt whether necessary change in health and care provision for the long term will be achieved through measures which merely address the symptoms of poor management of many chronic ambulatory care-sensitive conditions (cacsc), namely excess unplanned admissions to acute providers. The priority for the Department of Health and NHS England should be to address the underlying structure of services and incentives which send so many patients with CACSCs to acute care in the first place. (Paragraph 128)

32. We agree that the service structures and incentives need to change to ensure patients with CACSC receive appropriate support in the community. In April 2014, in partnership with NHS England, we published *Transforming Primary Care*, which set out how the NHS will provide more proactive, personalised, joined up care for those people

with the most complex health and care needs. The two main components involved in this are:

- the proactive care programme, which will provide over 800,000 people with the most complex needs with a proactive and personalised programme of care and support, tailored to their needs and views. This includes a named accountable GP and a care co-ordinator; and
- a named, accountable GP for all people aged 75 and over, who will have overall responsibility for and oversight of their care.

33. Through the integrated care pioneers programme and BCF, the Government and NHS England are promoting integration of services to manage CACSC in a more proactive and joined up way, which will help to avoid unplanned admissions, reduce nursing home admissions, and reduce delayed discharges. The BCF will help improve care for people out of hospital by tackling expensive pressure points in the system like A&E and providing greater investment in joined up services which incorporate both health and social care. Revised BCF guidance was launched on 25 July 2014, with a requirement for local area plans to be revised to achieve a reduction in emergency admissions.

34. NHS England considers support for people with LTCs when identifying the key national priorities for incentive schemes for commissioners and providers each year. For 2014-15, priorities include a quality premium measure incentivising CCGs to support people with specified LTCs effectively to avoid unplanned hospital admissions. Both the quality premium and Commissioning for Quality and Innovation payment framework include provision for commissioners and providers to develop local priorities for incentivisation, and a significant number of such local measures focus on LTCs. There is also a close inter-relationship between incentives and the development of pricing models that support people with LTCs, such as the Year of Care.

Evaluating the effect of integrated care services

While the prevailing assumption may be that people with long-term conditions would welcome treatment being provided through community or primary care as close to home as possible, this approach should not be taken for granted in the design of systems to support the management of long-term conditions. Many conditions will continue to require treatment to be provided in specialised secondary care settings. (Paragraph 135)

Robust evidence on the long-term clinical effectiveness and cost-effectiveness of large scale changes to the mix of services for long-term conditions is lacking. We consider that such evidence is vital to making the case for, and informing the design of, any form of sustainable service change which is to command widespread support. We therefore recommend that NHS England commission sufficiently rigorous studies of the effectiveness of services for people with long-term conditions which are delivered through integrated models of care, and that the outcomes for health and for cost-effectiveness across all settings are regularly and rigorously evaluated. (Paragraph 149)

35. We agree that it should not always be taken for granted that it is possible to provide treatment through community or primary care as close to home as possible. In some instances, it may be necessary to treat patients in hospital settings. NHS England is working to deliver personalised care planning,

which in some instances will mean that some of the treatment will be provided in a secondary care setting to meet the needs and preference of that individual.

36. NHS England acknowledges the importance of gathering evidence and commissioning research on the effectiveness of services for people with LTCs which are delivered through integrated models of care. NHS England will use evidence to evaluate the services it commissions and expects CCGs to do the same.

37. As set out in our response to the committee regarding the 14 integrated care pioneers, we have commissioned the Policy Innovation Research Unit at the London School of Hygiene and Tropical Medicine to carry out an independent early evaluation of the pioneers programme, whilst also seeking to commission a longer-term independent evaluation of it.

Identifying gaps in condition-specific guidance

We recommend that NHS England review the condition-specific guidance, quality standards and support available to commissioners from the NHS, from NICE and from third parties with a view to identifying and filling gaps in the support available to commissioners. (Paragraph 167)

38. There is a vast range of condition-specific guidance available for commissioners and clinicians to consider in the delivery of clinical services and the management of patient care. NHS England has sought to work with NICE on its approach to clinical guidelines and quality standards, referring topics for development to NICE where a need is identified, which is reflected in NICE's current work programme. In addition to this, NICE Evidence Services provides an online portal for easy access to evidence, accredited guidance and other products in health and social care that cover a wide range of topics.

Ensuring local engagement on local priorities

Guidance from the Department of Health and NHS England will be vital in assisting commissioners to shape the change in services for long-term conditions, but the centre must not prescribe solutions which local health economies are better placed to determine. The contribution of each Health and Wellbeing Board to the determination of commissioning priorities for long-term conditions across each local area will be significant. Boards have a vital contribution to make to the development of the broadest appropriate range of services across the area they serve, taking into account the demand for patient choice. Similarly, commissioners must be flexible and innovative in identifying the providers to deliver the mix of services which will best achieve the objectives for management of long-term conditions in their area. (Paragraph 168)

We recommend that commissioners should engage providers and the public as fully as possible in discussions about objectives for health and wellbeing outcomes in their local area and how they might be best be achieved. Commissioners should also explicitly relate payment to outcomes achieved. Local Healthwatch organisations have a role to play in examining how commissioning priorities have been delivered. (Paragraph 169)

39. We welcome the Committee's recognition of the vital contribution that Health and Wellbeing Boards (HWBs) can make towards determining the commissioning priorities and range of services at local level. As set out in their statutory duties, HWBs

provide a forum where all commissioners can come together to jointly plan services to meet the needs of local populations. HWBs are responsible for carrying out JSNAs to identify the current and future health and social care needs of the local community. In doing so they must involve their local Healthwatch, people living or working locally and, where relevant, district councils. Additionally, HWBs may consult any person or organisation they think is appropriate. Based on their findings, they must develop a Joint Health and Wellbeing Strategy (JHWS) to set out joint priorities for local commissioning to meet local needs identified by the JSNA. The JSNA and JHWS must have regard to the Government's Mandate to NHS England and these inform local authority, CCG and NHS England commissioning plans.

40. In *Everyone Counts: Planning for patients 2014-15 to 2018-19*, NHS England set out bold ambitions, asking commissioners to work with providers and partners in local government to develop strong, robust and ambitious five year plans to secure the continuity of sustainable high quality care for all, now and for future generations. This includes plans for the integration of local services under the BCF and, looking forward, locally determined commissioning plans for the integrated personal commissioning programme, recently announced by NHS England.

Outcome based commissioning

The development of a funding model which supports a Year of Care approach to payment for the treatment of long-term conditions, rather than an approach to funding based on episodes of care, is welcome. We look to NHS England and the Department of Health to collaborate with Monitor in refining, developing and implementing this approach to funding for long-term conditions, based on an evaluation of the experience of the model in the early implementer sites. (Paragraph 178)

Monitor has indicated that a final version of the joint long-term strategy on reform of the payment system will be published in the summer of 2014. We recommend that this strategy explicitly include processes to identify and eliminate perverse incentives in the present payment structure and to develop systems which incentivise models of care centred upon all the needs of the service user. We further recommend that Monitor and NHS England evaluate the results of any tariff flexibilities used in the 14 integration pioneer sites, as well as the general flexibilities introduced in the 2014/15 tariff, and that the interim and final findings of the evaluation should be published. (Paragraph 184)

41. We welcome the Committee's support for the Year of Care commissioning model. This is a four year programme (which commenced in 2012-13) and is designed to gather evidence and best practice to support the development of a capitation funding model for integrated care. There are six early implementer sites involved in the programme. Work so far has focused on identifying the cohort and categories of patients that would benefit most from an integrated care approach. Activity on these patients is then tracked across all provider landscapes (acute care, community, mental health, social care and primary care) in order to determine a capitated Year of Care budget for them. This year, the sites are "shadow testing" these budgets whilst exploring innovative ways of contracting for integrated care based on outcomes and risk sharing approaches.

42. As previously set out, the Department has commissioned the Policy Innovation Research Unit at the London School of

Hygiene and Tropical Medicine to carry out an independent early evaluation of the integrated care pioneers in the context of the BCF. This evaluation will consider financial incentives, contractual forms and budgetary innovations put in place to implement the pioneers' plans. The final report on this evaluation is due to be submitted to the Department in summer 2015.

43. Monitor has also responded directly to the Committee to provide additional detail in response to this recommendation.

Parity of esteem between physical and mental health

We find it difficult to understand how parity of esteem between physical and mental health services can be established, let alone maintained, when Monitor and NHS England have introduced a pricing structure for 2014-15 which has the explicit effect of reducing expenditure for mental health services at a greater rate than expenditure on acute services to treat physical conditions. We agree with the Minister of State that the differential pricing structure is flawed: in our view, it risks a disproportionate reduction in funding to mental health services. Monitor and NHS England must set out in their response to this report what steps they plan to take to support parity of esteem, both through the present tariff system and their proposals for tariff reform. (Paragraph 186)

44. The 2015-16 tariff engagement document was published by Monitor and NHS England on 18 July 2014. The ambition of the payment system for services such as mental health, where there are no national prices, is to enable a person-centred approach to care, to support delivery of evidence based treatments and to promote parity between physical and mental health. The mental health proposals have been informed by the parity of esteem programme. There are three elements of the tariff engagement document which relate specifically to mental health:

- the clear signal that unaccountable block contracts should end, and that transparent payment approaches should be implemented;
- guidance on developing local payment variations and some specific examples on what further work is proposed; and
- strengthened messages on mandatory data submission requirements, which are a vital tool in understanding patient needs, understanding costs and assessing value for money, and the enforcement of those requirements.

45. The engagement document makes it clear that quality and outcomes must be central to all payment mechanisms and that payment should be based on the mental health cluster currencies, unless other local payment variations are agreed for all or part of the contract. One local payment example provided is for liaison psychiatry, which supports the integration of mental and physical healthcare, and delivery of parity of esteem. NHS England and Monitor believe these local payment examples will support the sector to move away from unaccountable block contracts.

46. Monitor has also responded directly to the Committee to provide additional detail in response to this recommendation.

Modelling the effect of commissioner plans on the acute sector

We note with approval that a requirement of participation in the Better Care Fund is for local NHS areas to engage with patients, service users and the public on proposals for new integrated services and the consequences for acute service

provision. Such engagement should be frank and comprehensive and should make the case for improvements in clinical outcomes and care quality.

Without an agreed package for change, and a corresponding commitment to implementation, any large-scale attempt to vary the mix of services for people with long-term conditions is unlikely to succeed. We recommend that NHS England, as part of its five year planning round, undertakes modelling of the effect of commissioner plans on the acute sector by 2018-19. The likely scenarios for each NHS England area should be referred to the relevant Health and Wellbeing Boards for scrutiny and debate. (Paragraph 199)

47. The BCF now requires CCGs and local authorities to secure an explicit commentary from acute providers on the implications of their planned service changes, setting out the extent to which they recognise and agree with the plans. NHS England has reviewed CCG five year plans to understand the different care models and ambitions which have been proposed across England. These will be reflected in NHS England's forthcoming five year forward view, due to be published in autumn 2014, and will inform NHS England's efforts to improve the sustainability of the NHS over the medium term.

ISBN 978-1-4741-1069-3