Agenda item 6
Health and Well Being Board
8 December 2014

Walsall Council

NHS
Walsall Clinical Commissioning Group

Better Care Fund – Outcome of Assurance Process and Setting Up the Pooled Fund

1.0 PURPOSE

1.1 To report the outcome of the assurance process over the September submission of the Walsall plan for the Better Care Fund, and actions required in response.

1.2 To report on the requirements on the Council and the Clinical Commissioning Group associated with establishing a pooled fund for the Better Care Fund from April 2015.

2.0 RECOMMENDATIONS

2.1 That the HWBB agree the approach adopted in Walsall's plan for the Better Care Fund for setting a 3.2% reduction target for the rate of emergency admissions to hospital in the calendar year 2015 compared to 2014.

2.2 That the Joint Commissioning Committee is asked to bring a recommendation to the Health and Well Being Board on the arrangements for hosting, together with legal and other requirements, for the pooled fund for the Better Care Fund in time for 1 April 2014.

3.0 ASSURANCE PROCESS

3.1 The Government has established a comprehensive assurance process of Better Care Fund plans that comprises regular checks against progress in preparing the submissions. It then monitors progress of implementation. The **National Consistent Assurance Review** and the results of the **Assurance Checkpoints** are together being used to approve each plan.

3.2 The outcome of the review is that all BCF plans fall into one of four categories: *Approved; Approved with support; Approved with conditions; Not approved.* This assessment was determined by a judgement on two dimensions: the quality of the plan submission and the risk to the deliverability of the plan.

3.3 The outcome for Walsall was *Approved With Conditions* and there were two conditions to be addressed:

GP case management of people aged over 75 years who are at risk of an avoidable emergency hospital admission

3.4 There is a National Enhanced Service Agreement with GP's that a minimum of 2% of the practice's adult population (aged 18 and older), identified as being at the highest risk of avoidable admission, will be case managed proactively. The main features of this scheme are as follows:

- Practices are to produce personalised care plans for patients on their case management register. Care plans are to identify a named accountable GP within the practice who has responsibility for the creation of each patient's personalised care plan. All care plans should be regularly reviewed as clinically necessary.

- Each care plan should also identify, if different to the named accountable GP, a care co-coordinator who would be the most appropriate person within the multi-disciplinary team to be the main point of contact for the patient or their carer to discuss or amend their plan. The care coordinator will also be responsible for ensuring that the agreed care plan is being delivered, that the patient or carer is informed of any changes made to the plan and keeping in contact with the patient or their carer at agreed intervals.

- Practices to provide vulnerable patients (identified through the above risk profiling) who have urgent queries with same-day telephone consultations or with follow-up arrangements where required.

- Practices to provide timely access via an ex-directory or bypass number to A and E clinicians, ambulance staff and care and nursing homes to support decisions relating to hospital admissions and transfer to hospital.

- Following discharge from hospital, practices to ensure that patients on the case management register or patients newly identified as vulnerable are contacted by an appropriate person (practice or community staff) in a timely manner to ensure coordination and delivery of care. Practices are also be required to review emergency admissions and A and E attendances of their patients from care and nursing homes. The system must also address how practices with large numbers of care and nursing home patients will meet this requirement.

- Practices to undertake regular reviews of all unplanned admissions and readmissions for vulnerable patients (defined as patients on the case management register or patients newly identified as

vulnerable) to identify factors which could have avoided the admission. Practices should also undertake monthly reviews of the case management register to consider what action can be taken to prevent unplanned admissions of patients on the register.

3.5 Walsall has locally included a sum of £1.3 million in the Better Care Fund for a Local Enhanced Service Agreement with GP's to provide case management of people aged over 75 years old who are at risk of a hospital admission. This is on the basis that it is closely tied in with the overall aims of the Better Care Fund which are to reduce the number of avoidable hospital admissions.

3.6 NHS England is seeking assurance that this scheme is not the same as the national scheme as described above. The Local Enhanced Service Agreement requires GP's to provide an additional service over and above the National Enhanced Service Agreement for people aged over 75 years old, because this is the cohort of patients, which based on previous experience, are more likely to access hospital services as an emergency.

3.7 The Local Enhanced Service Agreement has set a target that by the end of the current financial year, 50% of all over 75s on the practice list will have had an individual care review which includes a medication review (this is excluded from the National Enhanced Service Agreement). As a result, each patient will have an individual care plan which will be reviewed regularly dependent upon individual patient need. This service is also joined to the Frail Elderly Pathway which has previously been agreed with the local providers; i.e. Walsall Healthcare Trust and Walsall Council.

3.8 This difference between the local scheme and the national scheme will be explained to NHS England.

Setting a 3.2% reduction target in the number of emergency admissions to hospital in the calendar year 2015 compared to 2014, instead of a national guidance target of 3.5%

3.8 The rationale for setting the local target at 3.2% is based upon an analysis of the trends in the number of emergency admissions to hospital during the last three years. In our plan submission as at April 2014 we stated that:

We have experienced one of the highest increases in emergency admissions during the last two years and so this will be particularly challenging for our local economy and we have rated this accordingly on our risk register. We have set a 3.2% reduction target for 2015/16 as part of a trajectory taking us to the full 15% reduction over the 5 year period to 2019/20.

3.9 This was the position up to the end of the financial year 2013/14 compared to previous years. Further analysis of the situation during the first six months of 2014/15 shows that the number of people from within Walsall (i.e. registered with a Walsall CCG General Practice) admitted as an emergency to The Manor Hospital has remained the same in 2014/15 compared to the first six months of 2013/14. However, there has been a continuing increase in emergency admissions to The Manor from people outside of Walsall in this period (3.2%) and a significant increase in people from Walsall admitted as an emergency to hospitals outside of Walsall in this period (18.2%).

3.10 This suggests that the rate of admission of Walsall CCG registered patients to the Manor has stabilised as a result of the impact of hospital avoidance schemes implemented in Walsall, but that these have had little impact on the rate of people from Walsall admitted as an emergency elsewhere. There is a need to examine the reasons for the significant rise in emergency admissions of people from Walsall to neighbouring hospitals and to take mitigating actions for this.

3.11 It also suggests that there is a need to continue the work with neighbouring CCG's to reduce the level of emergency admissions from people outside of Walsall – particularly in Staffordshire, but also Sandwell – to The Manor.

3.12 From this it can be concluded that the recent trend for a continuing increase in emergency admissions has been reduced to some extent for Walsall CCG registered patients in the Manor, and the earlier rate of increase in emergency admission to The Manor of people from outside of Walsall has reduced, but is still increasing.

3.13 Further time is needed before the schemes currently being implemented (i.e. GP and Community case management as described above) which form the substance of Walsall's BCF plan will impact on the rate of admission and so a 3.2% target has been set for 2015. The aim is to be able to set a more ambitious target for 2016.

3.14 In summary, Walsall Healthcare NHS Trust, as a provider, experienced an 8.4% increase in this area of activity from 2012-13 to 2103-14, compared to the national average rate of 5%. A further review of the six month period April to September over the last 3 years, 2012-13 to 2014-15, shows that the rate of admissions for Walsall residents to The Manor has stabilised which supports the theory that the commissioning and implementation of the new schemes which are within the BCF are starting to achieve the aim of reducing the demand in this area. If we had done nothing this would have continued at above national average. In addition, the rate of increase of people from outside of Walsall to The Manor has reduced, but there is still a 3.2% increase. Finally, there has been a significant rise(18,2%) in the number of people from Walsall admitted as an emergency to hospitals outside of Walsall and this also needs attention.

3.15 This is the rationale for setting a lower target in 2015/16 of 3.2% reduction in emergency admissions for people from Walsall, compared to the national guidance figure of 3.5%.

4.0 ESTABLISHING A POOLED FUND

4.1 Walsall has been operating a Section 75 (National Health Act 2006) pooled fund arrangement in partnership with the CCG (previously the PCT) since 2009 and so is well placed to establish arrangements for a pooled fund for the Better Care Fund. Clarity is needed on the financial arrangements; the procurement requirements; and the governance requirements. Comments on each of these are as follows:

Financial Arrangements

4.2 The current Section 75 agreement is based on a principle of 'simultaneous financial responsibility' whereby the Head of the Joint Commissioning Unit is simultaneously responsible for budgets within both the Council and the CCG and the members of the JCU have a dual role across both health and social care systems. This would have been a suitable arrangement for the BCF, but the guidance makes clear (Para 20) that all of the funding (circa £24 million per annum in 2015/16) must be hosted by one or other of the agencies.

4.3 The contributions to the pooled fund will be circa £21.5 million by the CCG and £2.5 million by Walsall Council. Approximately £10 million of the CCG contribution to the pooled fund is a direct contribution to the Council budget for social care services and does not transfer as a delegated responsibility. The remainder of the CCG funding is current expenditure that forms part of block contracts between the CCG and NHS providers, with other providers such as care homes, or for primary care services.

4.4 Should it be agreed that the Council will host the pooled fund for the BCF then there will need to be both a Section 75 agreement for funding that transfers as a delegated responsibility, and a Section 256 agreement for funding that transfers as a direct contribution to the Council budget. This can be arranged under a broader set of terms and conditions and principles for partnership working, and this will equally need to incorporate the other pooled fund for learning disability services and other funding transfers between the CCG and the Council.

4.5 Should it be agreed that the CCG will host the pooled fund for the BCF then there will need to be agreement about how the £2.5 million Council contribution to the pooled fund transfers to the CCG and then what accountability mechanisms should be applied to this funding. The simplest arrangement may be for the funding to transfer back again, but there would need to be a governance route for this, (e.g. Joint Commissioning Committee). Further guidance is being sought on

whether this funding would need to be transferred to the CCG as part of a single pooled fund or could simply remain in the Council.

4.6 The current Section 75 agreement does incorporate a pooled fund for learning disability services (circa £32 million per annum) which is hosted by Walsall Council. The CCG contributes just under one third of the funding for this arrangement, and the Council is acting on behalf of the CCG when it commissions services as a delegated responsibility. The current Section 75 agreement also covers transfers of funding for Free Nursing Care (FNC) and Continuing Health Care (CHC) and joint commissioning of mental health services.

4.7 Legal advice has been sought on the future legal joint arrangements for pooled funds and transfers.

4.8 Whichever agency hosts the pooled fund for the BCF, there will be additional work on financial management and thought will need to be given as to required capacity for this. This may be based upon a principle of joint working between the current finance teams rather than specific joint appointments of finance staff.

4.9 The Joint Commissioning Committee is continuing to look at these issues and will bring a recommendation back to the Health and Well Being Board. The Council has informally indicated its interest in hosting the pooled budget, however the detailed negotiation and recommendation still needs to be carried out and agreed to be brought to through the Health and Wellbeing Board early in 2015 to be formally decided by the Cabinet of the Council and the Governing Body of the Walsall Clinical Commissioning Group.

Procurement and Contract Management

4.9 Regardless of the hosting arrangements for the pooled fund, there will also be additional work on procurement and contract management. One example of this is that there are currently no formal contracts or service specifications for Council provided services which will be funded by the BCF (e.g. reablement service, and some elements of assessment and care management).

4.10 Joint work is currently underway to map the current contractual arrangements for services that will become funded under the BCF. Current contract arrangements can be classified under three main headings:

- Services contracted as part of an NHS block contract between the CCG and NHS Providers (e.g. Walsall Healthcare Trust);

- Services commissioned under more commercial contracts with the independent sector (e.g. the joint framework contract with care

homes, or service level agreements with registered social landlords or voluntary agencies);

- Services provided as in-house Council services.

4.11 The Council Procurement Team and the CCG Contracts Team are already working closely together on these contractual arrangements linked closely to the Joint Commissioning Unit. The two teams are also working closely on the contractual arrangements for Public Health funding that have become part of collaborative contractual arrangements between the Council and the CCG, and some aspects of children's services.

4.12 The CCG is currently funding one post in the Council Procurement Team to provide procurement and contract management support to joint commissioning arrangements.

Governance Arrangements

4.13 Formal pooled fund arrangements require explicit agreed joint governance arrangements. There is currently a Joint Commissioning Committee (JCC) overseeing the work of the Joint Commissioning Unit which is leading the work on the development of the plan for the Better Care Fund. The JCC reports on this work to the Health and Well Being Board (HWBB). There is an outstanding issue of whether providers are to be invited to join the HWBB (e.g. Walsall Healthcare Trust). If so, then the JCC would not be able to report to the HWBB on commissioning matters. This is currently under review.

5.0 IMPLEMENTATION OF THE BETTER CARE FUND

5.1 Our plan for action is focused primarily upon 2015/16 and made up of a number of elements of community based change schemes and programmes that we have consolidated under eight main headings:

1	Integration of Community Services
2	Transitional Care Pathways
3	Assistive Technology
4	Dementia Care Services
5	Mental Health Services
6	Support to Carers
7	Long Term Social Care – Community and Residential
8	Voluntary and Community Sector Impact on Hospital Flows

5.2 For each of these there is an identified operational lead manager and a lead commissioner, and they are implementing plans which when brought together make up the plan for the Better Care Fund. A workshop for the Better Care Fund work-stream leads is being held in December to clarify the requirements of managing their work-streams, and to ensure a consistent and co-ordinated approach across the work-streams.

5.3 Much of the work that is underway was being implemented as part of broader plans and strategies within Walsall CCG (i.e. 2 year Operating plan and 5 year Strategic Plan) and Walsall Council, and are incorporated in to the Health and Well Being Strategy. Further work over the coming months will strengthen the links between these plans and work-streams for 2015/2016.

6.0 CONCLUSION

6.1 The funding that has been incorporated in to the Better Care Fund was not new funding, and so there are prior arrangements for the governance, financial management and procurement/contract monitoring of this expenditure, largely based upon current joint commissioning arrangements between the Council and the CCG. These arrangements need to be jointly reviewed to reach agreement on hosting the pooled fund; the associated financial and procurement infrastructure; and to confirm the governance arrangements.

6.2 The Joint Commissioning Committee will bring recommendations to the Health and Well Being Board early on 2015.

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