Agenda item 19

Cabinet – 13 March 2013

Joint Commissioning – Transfer of Section 75 Agreement from NHS Walsall to Walsall CCG

Portfolio: Councillor McCracken, Social Care and Health

Related portfolios: None

Service: Adult Social Care and Inclusion

Wards: All

Key decision: Yes

Forward plan: Yes

1. Summary

To transfer the Section 75 Partnership Agreement for commissioning of services between Walsall Teaching Primary Care Trust ("NHS Walsall") and the council dated 2 December 2009 ("the Section 75 Agreement") to be between Walsall Clinical Commissioning Group and the council from 1 April 2013.

2. Recommendations

That Cabinet approve the transfer of the Section 75 Agreement between Walsall Clinical Commissioning Group and the council from 1 April 2013; and delegates authority to the Executive Director of Adult Social Care and Inclusion in consultation with the Portfolio Holder for Social Care and Health and the Head of Legal and Democratic Services to approve the form of transfer and to sign or authorise the sealing of any deed or contract or other related document to effect this transfer from 1 April 2013.

3. Report detail

3.1 In July 2009 the council entered in to a groundbreaking joint commissioning arrangement with NHS Walsall based upon a principle of 'simultaneous financial responsibility' whereby a single post-holder would have direct financial responsibility within both the council and NHS Walsall and thus be able to align budgets more effectively, and to align the work of the commissioning teams to bring about more effective integration of the commissioning process.

3.2 The legal basis for the agreement was Section 75 of the National Health Act 2006.

3.3 The July 2009 Cabinet report outlined how "the creation of a Joint Commissioning Unit ("JCU") would be a vehicle to better align the commissioning of services between adult social care and NHS Walsall. Pulling together the resources of

commissioning of health and social care services in this way would ensure that the most efficient use is made of financial and human capacity thereby delivering the best possible outcomes to the vulnerable people of Walsall. This proposal is fully in line with council policy to improve the health and wellbeing of the people of the borough."

3.4 The current reorganisation within the NHS means that Primary Care Trusts will cease to exist from April 2013 and so the commissioning function of NHS Walsall will transfer to Walsall Clinical Commissioning Group (WCCG). WCCG has indicated its support to continue the joint commissioning arrangement with the council based upon the success of the last three years.

Rationale and Measures of Success

3.5 The key rationale is that all users of social care services are also users of health services, and can experience frustration from the systems being separate. Combining funding responsibility does not resolve this issue, but does reduce the opportunity for disputes at the front line (i.e. around eligibility for Continuing Health Care) and hastens decision making around funding of care packages.

3.6 This in turn reduces the extent of delays awaiting resolution of funding arrangements. It sends a clear message to local front line workers in all locations that partnership working is the name of the game with a commitment from senior management and above.

3.7 The driver is all three elements of the phrase 'value for money'; meaning improved outcomes for people using services, higher standards, and greater cost effectiveness.

3.8 The JCU is a strategic operation, and so works behind the scenes as the 'cement between the bricks', binding the health and social care system together. Success is therefore measured indirectly. Some KPI's are relevant e.g. low level of delayed discharges; reduced emergency admissions to hospital; reduced residential placements; reprovision of adults in residential care to supported living within the Borough; Looked After Children, etc. However, the main goal is achievement of more strategic objectives as set out in the NHS QIPP programme, and achievement of council efficiency savings.

3.9 Combining funding responsibility in a JCU provides an opportunity to combine contractual frameworks, e.g. for purchase of care homes and home care services thus driving down fee levels. There is an opportunity for Personal Health Budgets to be implemented via council systems for personalisation, thus reducing duplication.

3.10 There is more widespread reduction of duplication of transactional processes around procurement/contract management, relationship management, service redesign, producing, for example, service specifications.

3.11 Success can also be seen in the greater extent of commitment and recognition of benefits from partnership working, thus supporting development of the Joint Strategic Needs Assessment (JSNA); and the development of a Health and Well Being Strategy via the Health and Well Being Board (HWBB). The HWBB

provides a new and more robust mechanism for governance over the work of the JCU.

3.12 For 2012/13 the council's Adult Social Care and Inclusion Directorate embarked on a third successive year of significant savings. This will result in an overall reduction in costs of over £22m for the 3 year period which began in 2010/11.

3.13 NHS Walsall achieved its QIPP targets for 2011/12 and is on track for its QIPP programme in 2012/13.

Benefits of Local Joint Commissioning

3.14 Benefits of a local tier of joint commissioning support include:

3.15 Reduced duplication between NHS CCG commissioning support and council commissioning (e.g. from combined roles; reduced administration; single points of reference);

3.16 Improved integration of commissioning of health and social care services, particularly the development of service specifications founded on integrated pathways delivered via a multiplicity of providers at local level (e.g. end of life services, care of the elderly, CAMHS);

3.17 Improved outcomes for people using both health and social care services (e.g. learning disabled people and people with mental health problems);

3.18 Improved opportunity to integrate the development of personalisation of social care with the development of personal health budgets (e.g. within continuing health care);

3.19 Expanding the opportunity to realise efficiencies for council's and QIPP targets for CCG's, particularly through a focus on proactive and early intervention within communities;

3.20 Improved opportunity for integration of health and social care commissioning with other local partnerships that are critical to the delivery of improved health and social care services i.e. housing partnerships, criminal justice partnerships, economic development partnerships;

3.21 Services being joined up and easy to use, requiring individuals to tell their story only once to an integrated team of professionals through a single assessment process;

3.22 Services being provided as locally and close to where people live as possible, with timely access and improved quality;

3.23 Building and maintaining mature and positive working relationships and partnerships to enhance service delivery;

3.24 Greater clarity of role and function of commissioning support at local level (e.g. NHS providers, private sector social care businesses, and so on have a single point of reference for both health and social care commissioning).

3.25 There is clear evidence that good joint commissioning at local level between the NHS and council's provides a more effective arrangement for some discrete areas of service (e.g. learning disability services; support for older people in the community to prevent hospital admission; mental health services; children's services) than separate arrangements.

3.26 A Joint Commissioning Unit will benefit all vulnerable people of the borough who require health and/or social care services, by creating a context for the optimal efficiency of financial spend and maximum flexibility in the commissioning of services.

3.27 There are no specific community safety implications of this report.

3.28 The creation of a Joint Commissioning Unit in itself will have no specific environmental impact though, in the commissioning of services, appropriate attention will always be given to the location of provision and consequent travel patterns to reduce adverse environmental impacts.

4. Council priorities

4.1 Commissioning programmes are developed in accordance with the priorities established by the Joint Strategic needs Assessment, the Health and Well Being Strategy and the Sustainable Community Strategy. These documents set out Council priorities.

5. Risk management

5.1 Risk

A full analysis of risk is built in to the approach. The major area of risk is around the breakdown of the partnership arrangement and any implications for either party. To model of 'simultaneous financial responsibility' mitigates against financial implications because the transfer of resources from party to the other is limited.

5.2 Performance Management

All JCU commissioning programmes are in line with national requirements for performance management of social care services and for the NHS.

6. Financial implications

The 'simultaneous financial responsibility' of the Head of the JCU takes the form of direct budgetary accountability for the commissioning budgets of the Adult Social Care and Inclusion Directorate of the council (a Net budget of £45.892 million for the commissioning service with budget setting responsibility for the entire Directorate Net budget of £70.921 million) and budgetary accountability for the mental health, learning disability, continuing health care, and intermediate care budgets of NHS Walsall (approximately £65 million).

There would not be an overall pooled budget for the new unit, however, the budgets will be "aligned" so that the manager can ensure effective and efficient use of resources and drive out economies of scale when purchasing and commissioning care on behalf of the two organisations. The existing pooled budgets for the Integrated Community Equipment Store (ICES) and Learning Disabilities would continue to exist in line with their pre-existing partnership arrangements.

The JCU has been audited separately by both the council and NHS Walsall and each time the outcome was for significant assurance.

7. Legal implications

NHS Walsall has received detailed legal advice from their external solicitors which concludes that the Health and Social Care Act 2012 ("the 2012 Act") discusses partnership arrangements and joint working throughout the document. Section 13N(3 states that the National Commissioning Board "must encourage Clinical Commissioning Groups to enter into arrangements with local authorities in pursuance of regulations under Section 75 where it considers that this would secure that Health Services are provided in an integrated way". The above shows the clear indication in the 2012 Act that Section 75 arrangements should continue and that Clinical Commissioning Groups should be involved in such exercises. Section 14Z1 of the 2012 Act states that each Clinical Commissioning Group must exercise its functions with a view to securing that health services are provided in an integrated way, where this would improve quality of services; reducing inequalities between persons with respect to ability to access services; or reduce inequality between persons with respect to outcomes achieved for them by provision of services. Thus, this reflects the previous Section 13 of the 2012 Act where Section 75 of the NHS Act 2006 is specifically mentioned.

The transfer of liabilities between PCTs and CCGs is intended to take place under a Transfer Scheme which has similar effect to a Transfer Order by the Department of Health, but does not require the documents to be placed before Parliament. In the latest guidance on Transfer Schemes, there is an Annex 2 which suggests a number of contracts which need to transfer and which can be transferred under the scheme. Under the heading "Material Contracts" on page 30 of that Annex 2, it refers to both Clinical Commissioning Contracts and Section 75 Agreements with Local Authorities which can be transferred through the Transfer Scheme. Thus the documents above clearly show that it is expected that the 2012 Act will allow Section 75 Agreements to be transferred through the Transfer Scheme to CCGs from PCTs.

The council internal solicitors have considered this advice, discussed it with NHS Walsall's external solicitors and are in agreement that this is the correct legal approach to follow.

8. Property implications

All commissioning programmes take account of the implications of commissioning intentions for property and asset management of providers.

9. Staffing implications

The current staff within the JCU comprise of 10.5 posts that are fully funded by NHS Walsall, 13.5 that are fully funded by the council and 7 posts that are 50/50 funded by each agency. Variations in the staff complement are agreed each year by way of the staffing schedule of the Section 75 Agreement.

10. Equality implications

Analysis of the impact of commissioning programmes is a standard feature of the process. Improving the efficiency of the commissioning process via an integrated approach makes compliance with equality requirements more effective.

11. Consultation

Consultation is a standard feature of the commissioning process. Internal consultation about the Section 75 Agreement has been undertaken within the council and WCCG.

Background papers

Development of a Joint Commissioning Unit with NHS Walsall – Cabinet Paper July 2009.

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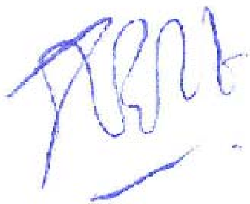

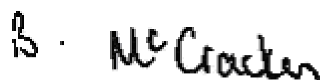

John Bolton
Executive Director
4 March 2013

Councillor McCracken
Portfolio holder
4 March 2013