Halton Clinical Commissioning Group

Complex Care

Business Case

2013 – 2015

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1. Introduction

There are increasing challenges for the Health and Social Care economy within Halton to be able to respond effectively to people's needs and provide high quality services within limited and reducing resources. Therefore we need to examine how we can do things differently to not only ensure value for money, but ensure that they are affordable.

Recent experiences in Halton in relation to funding for people with complex needs have challenged the local system in responding in a person centred way to a person's needs and offer value for money in delivering high quality health and social care.

The outcomes and discussions within this process indicated a number of areas of learning for both the Local Authority (LA) and Halton's Clinical Commissioning Group (HCCG).

These areas centred on the need to improve joint working between health and social care partners, and have provided us with the opportunity to reconsider our approach to supporting people with complex needs in Halton and the opportunities that could be realised by adopting an integrated model of working.

The aim of this Business Case is therefore to outline the mechanisms of how pooling health, social care resources and the alignment of systems will not only improve effective and efficient joint working, but more importantly improve the pathways, speed up discharge processes, transform patient/care satisfaction and set the scene for the future sustainability of meeting the current and future needs of people with complex needs.

In summary this paper underpins:

- A real belief that a closer working relationship can deliver positive health and social care outcomes for individuals within Halton;

- The financial challenges facing both health and social care are significant. Growth in public sector expenditure will be constrained for several years to come and hence there is a responsibility to secure efficiencies and drive service improvement;

- The need to look beyond traditional boundaries and assess ways of doing things differently;

- The need to retain the local links to influence the future shape of health and social continuing care within Halton; and

- The need to ensure we respond to the challenge within the recommendations of the Winterbourne review.

2. Context

2.1 National Context

Delivering Health and well-being improvements for people with complex needs is challenging, it isn't just about treating illness; it's about delivering personalised, responsive, holistic care. There are huge benefits for everyone in getting it right - for the NHS, local authorities, the third sector and most of all the people who use our services. It is therefore crucial to plan and ensure the efficient and effective use of health and social care resources.

There has been much research and evolving national policy supporting the move to personalised care and the closer working together of Health and Social Care Services to improve the flexibility of organisations in respect of the use of their resources, responsiveness, innovation etc. to enable organisations to offer improved services to people.

Most recently this has involved the publication of **C*aring for our Future: Reforming Care and Support (2012) White Paper*** and the ***Draft Care and Support Bill (2012)*.**

The White Paper outlines an emphasis on organisations working together to provide high quality, integrated services built around the needs of individuals. The aim is to enable local areas to transform their services and to deliver better integrated care that not only saves money across the two systems, for example by supporting people to maintain their independence in the community for as long as possible, but achieves better outcomes for individuals.

The draft Bill published will provide the enabling legislation for the reforms in the White Paper, for example it sets out a duty on the LA to promote the integration of services, along similar lines to the duty on the local NHS already enacted by the ***Health and Social Care Act (2012).*** In addition, it will provide for future duties of co-operation which encourage local partners to work together to improve the wellbeing of local people.

These are not the only drivers for integration/change; others include the current ***financial climate.***

Both the NHS and LAs need to make significant budget savings over the next 3 years. In addition to LAs expected reduction in spending (by 6.5% on average), the NHS needs to make up to £20 billion of efficiency savings by 2015 under the Department Of Health's Quality, Innovation, Productivity and Prevention initiative (QIPP).

These financial pressures will have a significant impact at the same time as the NHS and LAs face transformation and demand for health and social care services rises.

As challenging financial constraints increase there is a danger that local systems will focus solely on their own organisations when identifying efficiencies, without the recognition that changes to one part of the system will have an impact on all other parts of the system.

Recent national events such as ***Winterbourne View*** also support the case for working together more closely.

An interim report completed by the Department of Health, following the Care Quality Commission's inspections of 150 hospitals and care homes for people with learning disabilities, has recommended a number of changes to the way we commission and provide services. Although the report is focussed on services provided to people with a learning disability it is also of relevance to all services commissioned and provided for people with a range of complex needs.

"…we must be taking action at a national and local level to support commissioners to redesign services towards the personalised model we expect, to commission for quality and outcomes and to improve the quality and safety of services."

The concept of working together/integrating services isn't new and has a long history. For example the ***NHS Act 2006*** introduced 'Health Act Flexibilities', which aim to foster partnerships between health and social care agencies and to bring down the barriers between health and social care. The use of these flexibilities enable partners to join together in designing and delivering services around the needs of users, rather than worrying about the boundaries of their organisations.

There is also range of evidence supporting integration, some of which is outlined in the ***King's Fund and the Nuffield Trust (2011) - The Evidence Base for Integrated Care*** paper, which not only outlines the range of evidence supporting the integration of care and the factors that need to be considered, but clearly outlines that 'Integration without care co-ordination cannot lead to integrated care'.

2.2 Local Context

As national reforms continue to take shape, work has already taken place locally to look more strategically at improving models for integrated working and this vision has been captured within the ***Framework for Integrated Commissioning in Halton (2012).*** The Framework outlines the current strategic landscape of commissioning across Halton and explores national good practice and has translated this into an action plan. Research from this work demonstrated the areas with stronger alliances and evidence of efficient systems where the areas with pooled financial arrangements.

The Framework has been agreed by Halton's Shadow Health and Wellbeing Board (18.7.12), and both HBC (4.7.12) and the CCG's appropriate governance bodies (20.9.12).

In support of the implementation of the Framework work is currently progressing in respect of the development of a Section 75 Partnership Agreement between Halton CCG and LA which will provide robust arrangements within which Partners will be

able to facilitate maximum levels of integration in respect of the commissioning of Health and Care services in order to address the causes of ill health as well as the consequences.

The development of this Agreement builds upon Halton's already well-established history of joint/partnership working in association with pooled budget and robust financial/performance management arrangements. An example of which is the current Intermediate Care Pooled Budget arrangements which have been established via a Section 75 agreement between HCCG and the LA.

The arrangements/agreement has been in existence for 5 years and although is due for review in March 2013 plans have already been drawn up to continue the agreement with Halton CCG; with the LA being the host organisation.

The Pool is designed to allow flexibility and consistency in the development and delivery of intermediate care services to meet agreed strategic outcomes and operational targets in the Borough. The agreement allows for underspends to be carried forward which has enabled the Partnership to release resources in times of pressure to increase capacity whilst achieving the required efficiencies.

There are a range of contracts with providers for different aspects of service provision and a focus on operating a single system for referral, assessment and pathways through and out of the services. All services have specifications and provide monthly performance information and exception reporting as required.

The following sections outline the local context in which services are currently commissioned and delivered within Halton in respect of population, levels of deprivation and health.

2.2.1 Population

Since 2001, the population of Halton has increased steadily to its current estimate of 125,800 (Census 2011). Table 1 below shows the population breakdown by age.

Table 1: Population of Halton, breakdown by age, 2011

	Total	**0-14**	**15-64**	**65+**
Halton	125,800	23,400	83,900	18,400

*figures may not sum exactly due to rounding

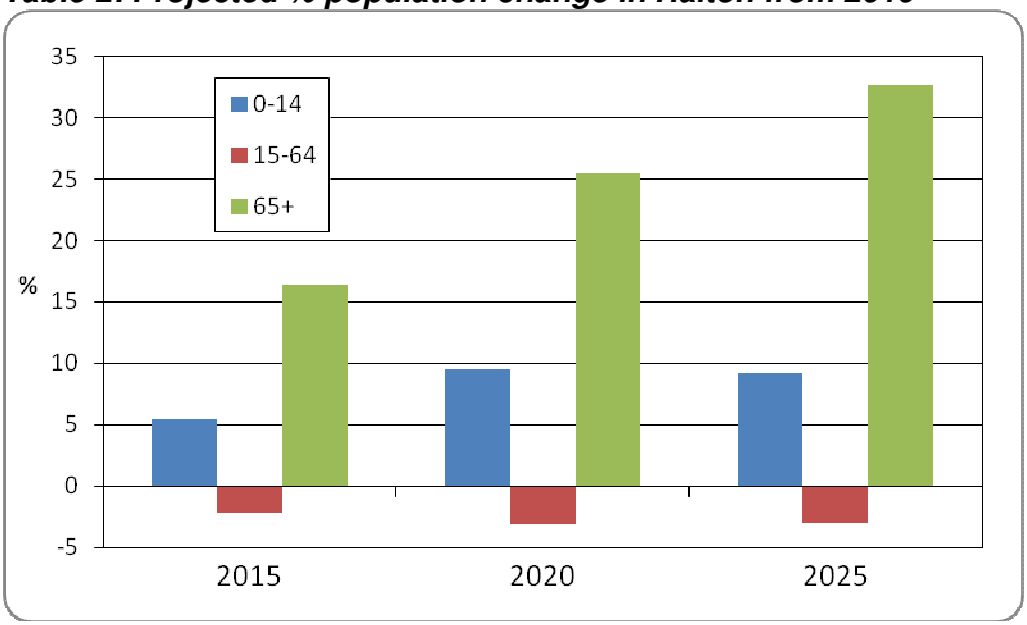
The total population rose from an estimate of 118,200 from the 2001 Census; this rise was found mainly in the Working Age range (15-64). This group went from 78,400 in 2001 to 83,900 in 2011. Whilst the older people population (65+) displayed the largest relative increase, with a rise of 15%.

2010 Subnational population projections are produced by the Office for National Statistics. The projections form a "baseline" view of what the population dynamics would be in the given areas if recent demographic trends were to continue into the

future. It is important to note that these projections are consistent across all local authorities in England.

In the long term (2010-2025), Halton's population is projected to grow by 7% from 119,600 to 128,100. This is still lower than the North West region which is projected to grow by 9% and nationally which is projected to grow by 12%. In Halton, younger people (0-14 year olds) are projected to grow by 9%, working age (15-64 year olds) are projected to decline by 3% with the older people age group (65+) projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025 (Table 2).

Table 2: Projected % population change in Halton from 2010



Source: ONS

Following national and regional trends, Halton's population continues to age with older people making up an increasing proportion of the population. The growth in older people will increase the demands for both formal and informal support. While small decreases in the working age population mean there are fewer people to provide and pay for this additional support. These projections are calculated on a national basis, and therefore do not take account of local level factors such as planned housing developments.

2.2.2 Deprivation (Index of Multiple Deprivation)

As a result of its industrial legacy, particularly from the chemical industries, Halton has inherited a number of physical, environmental and social problems. We have been working to resolve these issues ever since the borough was formed in 1974.

Halton shares many of the social and economic problems more associated with its urban neighbours on Merseyside. The Index of Multiple Deprivation (IMD) for 2010 is one of the most comprehensive sources of deprivation indicators, as some 37 different indicators are used. It shows for example that overall, Halton is ranked 27th nationally (a ranking of 1 indicates that an area is the most deprived), which is third highest on Merseyside, behind Knowsley and Liverpool, and 9th highest in the North

West. Other authorities, St Helens (51st), Wirral (60th) and Sefton (92nd), are all less deprived compared to Halton.

The IIMD for 2010 suggests that deprivation has remained relatively constant in the borough, since ranking 30th in 2007 there has been a slight change in Halton's ranking; however the IMD score has remained the same. The proportion of Halton's population in the top category (i.e. the 10% most deprived lower super output areas nationally) has also remained the same between 2007 and 2010 at 26%.

It is important to note that the IMD 2010 uses mainly data from 2008, and the IMD 2007 uses mainly data from 2005. Although this provides the most up-to-date overview of deprivation at a national level, more recent local level deprivation data will be available.

2.2.3 Health Profile

Halton's all age, all-cause mortality rates for both females and males are higher than regional and national rates (2008-10). Life expectancy in Halton is 75.5 years for males and 79.6 years for females – these are lower than national levels, with the female life expectancy being one of the lowest in the country. Latest figures show that Halton has the highest rate of early deaths from cancer in England.

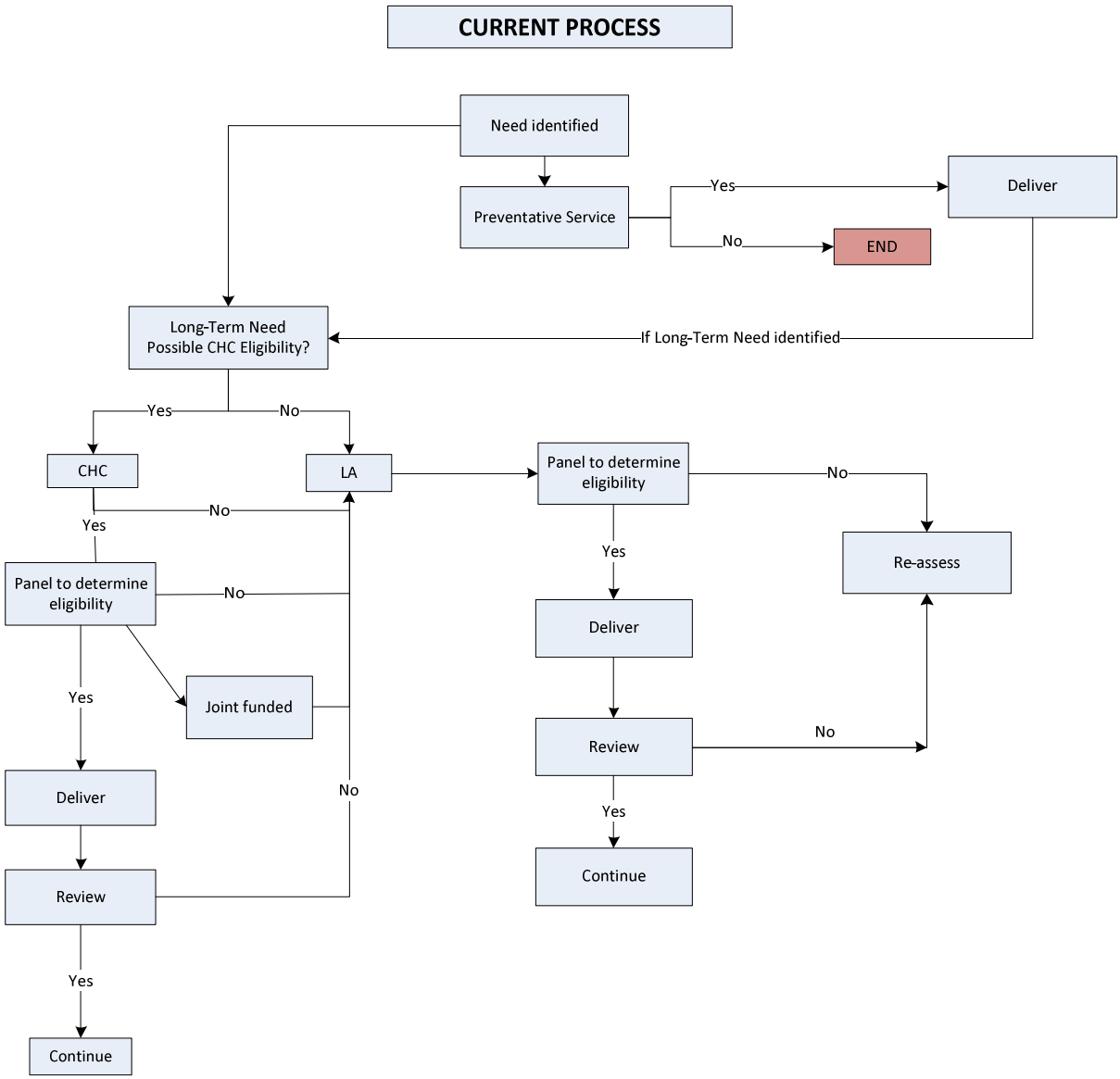
3. Associated Pathways

3.1 Current Pathway

The multiple processes currently in place associated with the provision of services to Adults with complex needs in Halton is fragmented across organisational boundaries and operational teams and involves social work teams, multi-agency multi-disciplinary teams, Community Matrons, District Nurses and Continuing Health Care assessment teams.

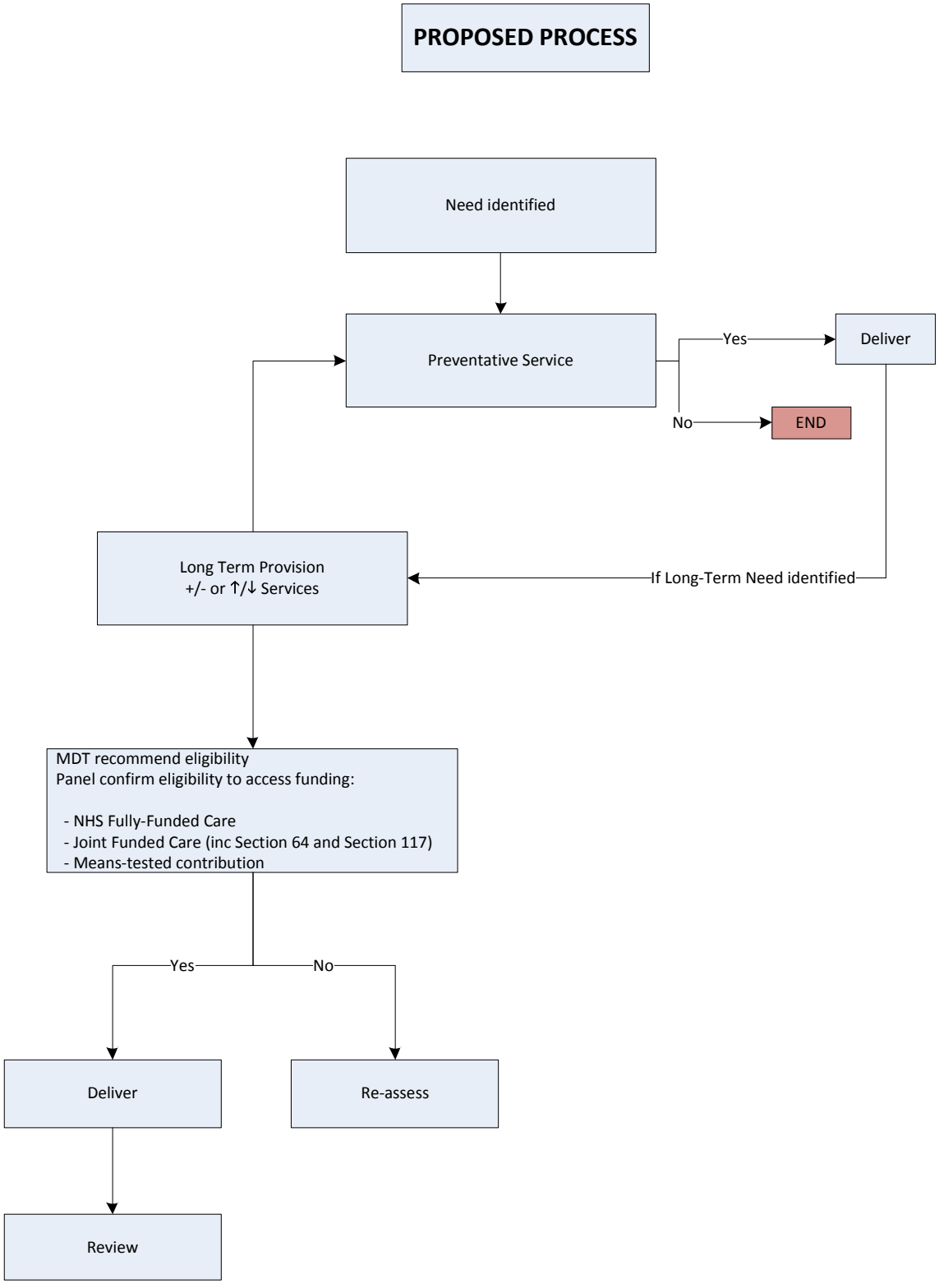
This presents challenges in achieving a whole system coordinated approach to the assessment and provision of services for people with complex needs and can lead to duplication, fragmentation, confusion for workers and individual service users, differential contract prices and monitoring arrangements with no real clarity on who is responsible for the overall commissioning of placements/packages of care.

The flowchart below represents the current pathway in place.



3.2 Proposed Pathway

The development of the new pathway outlined below in addition to a pooled budget arrangement for all community care, including Intermediate Care, would enable Practitioners to work more effectively across organisational boundaries, utilising the flexibility within the pooled budget to commission holistic services.



It is important to highlight that local decision-making processes associated with the proposed pathway will continue to be operated via a Panel process with appropriate representation from Health and Social Care partners, for all funding health and social care decisions.

The role of the Panel will include:-

- verifying and confirming recommendations on eligibility by the MDT;
- agreeing required actions where issues or concerns arise;
- ensuring consistency and quality;
- ensuring preventative services are utilised to full effect, including Intermediate Care, Telecare/Telehealth and Reablement;
- ensuring value for money;
- ensuring out of borough placements are only agreed after all local options have been explored; and
- ensuring all people placed out of borough are given the option of returning to a more locally provided service.

The new arrangements would aim to achieve:-

- Better management of crisis;
- Promote independence, empower users and allow them to take control of their lives;
- Prolong and extend quality of life;
- Provide the most intensive care in the least intensive setting;
- Move away from a reactive, unplanned and episodic approach to care;
- Deliver integrated long term care;
- Offer a sustainable joint oversight of financial arrangements; and
- Service users are safeguarded.

3.2.1 Commissioning/Monitoring Arrangements

Although the Panel process will involve undertaking individual commissioning arrangements, the formal commissioning and monitoring arrangements associated with the delivery of services to those with complex care needs will be undertaken by HBC's Commissioning and Quality Assurance Teams. Additional resources may be required to support the existing team, and will be considered as part of the implementation of this business case.

Associated functions will include:-

- Local market development/availability - There is the potential to manage the market more effectively, utilising more robust procurement processes in order to manage/contain the general increase in costs;
- Ensure value for money contract prices, to ensure quality provision and adults are appropriately safeguarded;
- Contract monitoring and management;
- Liaison with MCSU in relation to specialist commissioning;
- Liaison with Care Quality Commission as appropriate;
- Collation of data; and
- Performance Management.

3.2.2 Governance Arrangements

A Section 75 (NHS Act 2006) Partnership Agreement will be developed outlining the provision of the Service. The Agreement will provide the appropriate legal framework in which HCCG and HBC will work together in order to achieve their strategic objectives of commissioning and providing cost effective, personalised, quality services to the people of Halton.

Amongst other elements, the Partnership Agreement will define the:-

- Outcomes and Objectives of the Agreement;
- Commencement, duration, review and termination of the Agreement;
- Governance and Accountability arrangements;
- Pooled Budget arrangements;
- Relevant legalities associated with a Section 75;

- Monitoring arrangements; and
- Performance Management arrangements.

Details of the pooled fund and the management of such will be outlined within the Partnership Agreement; the LA will be the host organisation for the pooled budget.

The pooled budget will be managed by a nominated HBC Operational Director (or above), as identified within the Partnership Agreement. The Pooled Budget Manager will have a clearly defined role and associated responsibilities for managing the pooled budget which will be outlined in the Partnership Agreement.

These overall arrangements/Agreement will be managed via the Complex Care Partnership Board, which will meet on a monthly basis during the duration of the arrangements/Agreement. The Board will be accountable to both HCCG's Governing Body and HBC's Executive Board. Membership of the Board will include:-

- HBC Executive Board Portfolio holder (Health and Adults) (Chair)
- HBC Executive Board Portfolio holder (Resources)
- Strategic Director, Communities, HBC
- Operational Director (Prevention and Assessment), HBC
- Operational Director (Commissioning & Complex), HBC
- Operational Director (Integration) HBC & HCCG
- Divisional Manager (Urgent Care) HBC
- Divisional Manager (Care Management) HBC
- Finance Manager HBC
- Chief Nurse HCCG
- GP Clinical Lead
- Commissioning Manager HCCG
- Director of Finance HCCG
- Principal Manager (Adult Safeguarding) HBC &HCCG

3.2.3 Performance Management Arrangements

A joint performance management framework (including targets) will be developed between HBC and HCCG to ensure the Pooled budget delivers the strategic outcomes and statutory responsibilities effectively. The responsibilities and actions of HBC and HCCG will be agreed and documented within the Partnership Agreement.

This framework will support the following strategic objectives:

- Delivering high quality care closer to home;
- Reduce the need for unnecessary hospital admission and readmission;
- Ensure the appropriate use of crisis intervention and short term support to promote independence;
- Promote the use of a range of technology to support independence and the management of risk;
- Ensure the proportion of placements in long term residential care are maintained at an appropriate level;
- Realise placements in Borough with out of Borough placements being the exception; and
- Improve the quality of care in the community and residential placements

Full details in terms of how the panel process will operate, formal commissioning arrangements, governance and performance management arrangements will be agreed through the development of the Section 75 Partnership Agreement.

4. Finance

The pooled budget will amalgamate 2 current pools into one i.e. Equipment and Intermediate Care Services. VAT, Audit and legal requirements will be subject to the same processes as current pools.

Finances within the Pooled Budget will consist of:-

- HBC Adult Social Care Community Care Budget (includes section 117 and jointly funded packages);
- CCG Continuing Health Care Budget (including Free Nursing Care, End of Life and jointly funded packages);
- CCG section 117 budget;
- HBC/CCG Intermediate Care pooled budget;
- CCG/LA Equipment budget (joint); and
- Reablement funding

NOTE

The Pooled Budget will also include any non-recurrent grants/funds that may currently exist or may exist in the future as agreed by HBC or HCCG e.g. Section 256.

The pool will not include:-

- Children and Young People;
- Mental Health Hospitals; or
- Hospices

For 2012/13, early indications show the budget to be in the region of £30,042,225 and more detailed work is on-going. This figure consists of:-

- HCCG = £11,390,380
- HBC = £17,006,845
- Non-Recurrent Section 256 = £1,645,000

5. Conclusion

Those people who are in receipt of long term care whether that is funding from Health or Social Care are those people in our communities with some of the most clinically complex and severe on going needs, so it is essential we have effective mechanisms in place to ensure that people we provide services to receive appropriate outcomes.

Often as people require intensive care in supported or care home environments and we enter into discussions about who funds which element of the service, the overall case management of these people can get lost in the discussions.

Historically, Halton has had its challenges with support to those with complex care needs and relationships between health and social care have been tested at times. However, with the emergence of the CCG and the local 'appetite' for the move to more integration it is an opportune time to review current practice in respect of the provision of care to those with complex needs.

The proposal contained in this Business Case aims to ensure that an integrated system is developed and appropriately managed, in addition to a formal pooled budget arrangement, to ensure that the resources available to both Health and Social Care are effectively used in the delivery of personalised, responsive and holistic care to those who are most in need.