NHS
Stockport
Clinical Commissioning Group

Integration of Health & Social Care Resources

Proposal for greater Integration & Pooling of Budgets 2016-2017

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

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Executive Summary

What *decisions* do you require of the Governing Body?

I. Agree additional pooling intentions for 2016-17,

II. Endorse direction of travel beyond 2016-17, and

III. Agree principals for next stage.

Please detail the key points of this report

The paper proposes a significant increase in the pooled budgets with SMBC from the current £24.8m to c£122m from 2016-17.

It argues that this is the national, regional and local direction of travel and will support greater integration of service delivery and help address the financial challenge we face. The paper proposes that initially we base the pool on a population cohort of people aged over 65 which matches well with the local authorities adult social care resources. It then sets out the principles that were applied to generate a proposed budget using this cohort as the basis before setting out the risks and principles for developing the new arrangement.

What are the likely impacts and/or implications?

- The intention of pooling resources is to drive efficiencies which will help tackle and address the health & social care forecast deficit of c£130m by 2019
- It will enable us to commission for value and drive integration and innovation of providers
- It will require new commissioning arrangements to be developed

How does this link to the Annual Business Plan?

- It is underpins the delivery of elements of this year's plan in particular design phase with Stockport Together, Proactive Care and the New Models of Care Vanguard programme
- It will significantly shape next year's plans

What are the potential conflicts of interest?

There are no significant conflicts of interest or direct opportunity for pecuniary gain or loss, but the Governing Body should be aware that the following will have an interest

- Attendees or Members of the Governing Body who represent SMBC
- GP members who as providers will see resources currently managed by the CCG transfer to the pool

• Management staff who may be affected by stronger joint commissioning arrangements
Where has this report been previously discussed?
Elements have been discussed at the Governing Body Away Day in May, a pre-board session in June, and the Strategic Leadership Team Meeting in June.
Clinical Executive Sponsor: Dr Gill
Presented by: Gaynor Mullins / Gary Jones
Meeting Date:
Agenda item:
Reason for being in Part 2 (if applicable)

Proposals for Pooling of CCG Budgets with SMBC 2016-17 and beyond

1. Decisions Required

i. Agree additional pooling intentions for 2016-17
ii. Endorse direction of travel beyond 2016-17, and
iii. Agree principals for next stage.

2. Summary of proposal

2.1 The CCG is proposing to increase the size of the pooling arrangements with Stockport Metropolitan Borough Council (SMBC) under Section 75 agreements from £24.8m to c£122.0m in 2016-17 (6.5% to c32.3% of CCG budget) and to go further in 2017-18. Any final agreement of the exact amount for 2016-17 will be made by the Governing Body subject to an agreement based on a set of key principles and a new section 75 agreement with effective management of risk. This decision will be made in early 2016.

3. Introduction and case for change

3.1 NHS Stockport Clinical Commissioning Group (CCG) and Stockport Metropolitan Borough Council (SMBC) have had a pooled budget agreement for a number of years. This has been successfully managed through a Section 75 agreement overseen by the Stockport Integrated Commissioning Board. The CCG's contribution to the pooled budget in 2015-16 is £24.8m as shown in table 1 below.

Service Area	**2015/16 Pool Contribution (£m)**
Non-Acute Services for Older People	3.808
Learning Disabilities	1.595
Continuing Health Care Beds	0.600
Mental Health	0.289
Better Care Fund	18.510
Total	**24.802**

3.2 Both nationally and locally there is a drive for greater integration of Health and Social Care. This is set in the context of the challenges we face in Stockport around an increase in the ageing population and the squeeze on public sector resources. Organisations cannot act unilaterally as the current Health & Social Care system is not affordable and to continue in this way will lead to funding / cost pressures not being tackled collaboratively by partners which ultimately impact on delivery of local services. It is therefore essential that partners within the economy work collaboratively to drive out efficiencies in service delivery. Integration is seen as critical to ensuring we have a both an affordable and sustainable health and Social Care system. Devolution of Health and Social Care resources to Greater Manchester will accelerate this change locally.

3.3 The Stockport Together Vision decision taken by the Governing Body in March is predicated on a shared ambition and goals across local health & social care commissioners and providers. Greater alignment of resources is essential if we are to address the £130m shortfall locally, which is based on demand for services continuing to rise at current rates and maintaining existing services in an unreformed health and social care system,.

3.4 To address the funding shortfall the current fragmentation of the health and social care system (and the health system on its own), and the perverse incentives to different providers to work against the interests of the system as a whole will need to be addressed. One option being considered locally is to commission for outcomes. True outcomes are outside the control of any single provider so this will necessitate a closer contractual arrangement between local providers. A greater coming together of providers will require a single commissioning strategy and this is supported by greater pooling. The resources held in the pool will be used as the funding source to commission at an 'affordable' level within the constraints of the pool and recognising the need to create incentives to Providers. This is the joint aim of the CCG and SMBC and will need the detail working through as part of the contracting workstream. **A fundamental pre-condition of pooling resources is that we enter into new contractual relationships (i.e. under different payment mechanisms) with our Providers.**

3.5 The Governing Body have been considering the scope of further pooling having discussed this at a pre-board meeting in June. We have also been discussing pooling with SMBC since the inception of the Better Care Fund in 2014. SMBC have already indicated their intentions on further pooling, and it is necessary that we align our

decision making with SMBC to inform discussions on 16-17 financial planning. Governing Body are asked to note that SMBC have indicated that if the scope and scale of financial pooling by the CCG does not meet with their expectation then SMBC will consider alternative options for delivering savings in 2016-17.

3.6 Therefore, Governing Body are being asked to consider an indicative budget and the principles underpinning it so that the executive team can have formal discussions with SMBC on a future pooled arrangement. Following those discussions the Governing Body will be asked to make a final decision as part of the planning and budget setting agreements in January or February 2016 to inform 2016/17 financial planning.

3.7 It will also be helpful if the Governing Body could endorse the approach beyond 2016-17 and the principles under which discussions with SMBC should take place.

4. Proposal for 2016-2017

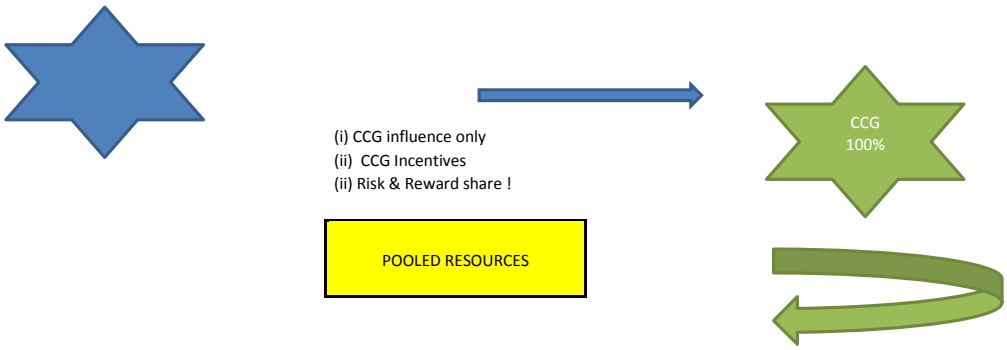
- Basis of proposal

4..1. In Scenario 1 below parties will pool resources by a desire to drive out better opportunities to deliver and share efficiencies for a similar cohort. Any decisions by one part will impact on the other.

Scenario 1

In Scenario 2 decisions of one party do not implicate or impact on the other. In this scenario any rewards are in effect a “windfall” to the other partner. Conversely would the other partner be willing to accept risk given “no influence”.

Scenario 2



Clearly scenario 1 is the better basis for a pooling arrangement.

4..2. We have then considered the best population cohort to support this. In doing so we have also looked at where the greatest opportunities for change will be given demographic pressures, current resource and performance issues. Ensuring the principle of commissioning for value remains possible it was also important to consider a cohort.

4.3 It is proposed that the primary cohort we consider using as the basis of commissioning for value and pooling is all-those aged 65 plus.

4.4 We are proposing that we focus on this particular cohort' as a group for four main reasons:

- Stockport already has a greater than average population of older people and this is predicted to grow faster than the national average in the next few years;
- This population consumes more financial resources per head of population than other cohorts and therefore is the area where most benefit can be gained from pooling and contracting differently;
- Given the governing body's intention to pool significantly more resources we needed a cohort that utilises a significant budget as this does; and
- It is the cohort that most closely aligns with the local authority social care budget.

4.5 We are deliberately not proposing a smaller cohort within this overall definition. We may have considered some definition of *"frail"* older people or a group of older people with a certain condition or set of conditions. Given the intention to move towards commissioning for

outcomes such narrow definitions would have limited the potential and incentive on providers to proactively manage people and looked only at efficient management. Given our desire on proactive and preventative services across the system this would seem self-defeating. (It would also pragmatically been a much more difficult task).

4.6 This thinking also lies behind our choice of 65 plus as the starting age. Resource use on average in Stockport increases sharply in the 65 and above cohort. However, this is not uniform across Stockport and we would want providers to have an incentive to address healthy life-expectancy as well as manage ill health and frailty efficiently. To do this well they will of course need to influence health throughout life, but at this stage of development of this new approach considerable work can be done to address secondary prevention and utilise social care preventative services.

5 Principles and Services/budgets to be pooled

5.1 Having decided on this cohort we then looked at service lines that best fitted the cohort. We did this utilising the principles below:

- Where current spend can be identified through PBR as directly related to the cohort then this will be pooled. This will include non-elective and planned (Outpatients and elective) activity.
- Where current spend is by a block contract but is clearly exclusively or almost exclusively spent on this cohort this will be pooled.
- Where current spend is on a service which is under block arrangements and for the whole population but where a reasonable assumption is that at least 75% of spend is on the cohort then this will be added. E.g. district nursing.
- Adults Continuing Health Care & Funded Nursing Care also closely aligns to this cohort.
- Where current spend is on a service area where the spend on the cohort is less certain the following principles will apply:
    - Secondary Care not included
    - Prevention, Primary and Community (including intermediate care) will be included
    - GMS/PMS contracts will not be included in 16-17 proposal as we do not have full delegated powers.

5.2 Prescribing costs are at this stage to be kept outside the pooled but will be in-scope as an aligned budget as a next stage. The costs of prescribing for this particular cohort cannot be easily determined and monitored on due to lack of information in this area and so any estimation is on a crude population basis only. The same issue also applies to GP Out of Hours service which is also on an arbitrary basis.

5.3 The table2 below sets out the proposed pool. Further detail will be developed in discussion with SMBC and the Governing Body should be aware that the figures are indicative.

Service area	**15/16 Plan Spend £m**
Non-elective hospital activity	29.1
A&E activity	3.2
Planned activity (Outpatients and elective admissions)	32.9
Community Services	10.1
Mental health services	8.0
CCG held GP contracts	5.8
Old Age Psychiatry	
CHC and FNP	8.1
Other elements of existing pool not in above (E.g. LD)	
Total	**97.2**

5.4 The values in Table 2 above represent the gross spend budgets before QiPP (savings target) has been applied to these in 15/16. Members should note therefore that these values will be amended to reflect QiPP target in moving to an 'affordability' basis. This aligns to the approach being taken by SMBC given reductions in cash limits.

5.5 The Governing Body are asked to agree this sum as the basis of our discussions with SMBC, noting that this needs to be reduced to reflect the QiPP savings relating to this cohort.

6 2017-18 and beyond

6.1 There were a number of other areas considered. These included children's services, other adult mental health services, and alcohol and drug services. We would look to pool further in these areas in 2017-18. As we develop new commissioning and contracting arrangements further other cohorts are likely to emerge. Devolution will also influence us in this direction. The Governing body are asked to endorse this direction of travel

7 Risks

7.1 Clearly making such a significant financial commitment to pooling carries with it risks as well as benefits.

7.2 The main risk which faces both partners is the financial risk of overspending against the Pool. There is already a risk share arrangement in place as part of the existing S75 Partnership Agreement which relates to the c£51m pooled budget which is based on a more fixed level of contribution and spend year on year. However, the new Pool will operate on a different basis with:-

- the CCG pooling resources which are activity based and therefore historically volatile in nature given demand pressures and PbR payment mechanisms
- SMBC contributing a reducing value over next 5 years into the pool given their reductions in central grant funding.

Any risk share will therefore need to take into account the above key factors in formulating a risk share agreement that covers these known issues.

7.3 Members are aware of the GM Devolution Agreement and GM localities need to be mindful of the emerging issues which will impact operating under this new devolved arrangement.

8 Principles underpinning final agreement

a. The Governing Body are asked to agree the following high-level principles as the basis for further negotiation with SMBC.

- There is full joint ownership of any pool and the quality and performance elements of any service commissioned

- The commissioning of services from the Pool will follow clinical best practice and guidance.
- The use of the Pool will be agreed by both parties
- Partners will be allowed full access to records to operate in an 'open and transparent' way.
- Robust financial control and reporting arrangements are in place.
- Audit inspection and reporting will be via host commissioner and all reports will be shared.

9 Next steps

a. Following the decision of the Governing Body the CCG will commence formal negotiations with SMBC to develop revised pooling arrangements.

b. The CCG will continue to work with SMBC through Stockport Together to develop new commissioning and contracting arrangements

c. The Governing Body will be kept informed of progress through the Chief Operating Officer's report

d. The Governing Body will be asked to agree the final pool, the revised Section 75 agreement and any changes in joint commissioning arrangements in early 2016.

Compliance Checklist:

Documentation		**Statutory and Local Policy Requirement**	
Cover sheet completed	Y / N	Change in Financial Spend: Finance Section below completed	To follow
Page numbers	Y / N	Service Changes: Public Consultation Completed and Reported in Document	n/a
Paragraph numbers in place	Y / N	Service Changes: Approved Equality Impact Assessment Included as Appendix	n/a
2 Page Executive summary in place (Docs 6 pages or more in length)	n/a	Patient Level Data Impacted: Privacy Impact Assessment included as Appendix	Y / N
All text single space Arial 12. Headings Arial Bold 12 or above, no underlining	Y / N	Change in Service Supplier: Procurement & Tendering Rationale approved and Included	Y / Na

		Any form of change: Risk Assessment Completed and included	n/a
		Any impact on staff: Consultation and EIA undertaken and demonstrable in document	Y / N