hfma briefing

Contributing to the debate on NHS finance
July 2014

The better care fund

Realising the benefits

Foreword

The Healthcare Financial Management Association (HFMA) is the representative body for finance staff in healthcare. It has a long track record in providing independent and objective advice, issuing authoritative guidance, delivering training and helping to spread best practice in financial management and governance.

We recognise the opportunities afforded by integration including the better care fund. In the coming months, the focus for clinical commissioning groups (CCGs) will be on:

- Quantifying impacts on emergency admissions
- Ensuring that acute hospitals are fully engaged
- Developing proper risk-sharing arrangements
- Ensuring that, through the fund, public money is appropriately used.

Given the risks that the planned benefits may not materialise, solid foundations are needed to ensure the benefits of the fund are delivered and the risks appropriately managed across health economies.

Much is at stake, and colleagues in health and social care continue to develop their plans working through the details of implementation across local health economies. The HFMA supports the need for the fund plans to be reviewed and refined. We are keen to see that plans contain a thorough assessment of costs and savings. Given the resources to be invested, the success or otherwise of the fund will have a big impact on the financial sustainability of the NHS. In short, we cannot afford for the fund to fail to deliver what is required of it.

This briefing focuses on identifying and realising benefits from the better care fund; measuring and monitoring performance; and identifying key risks to the success of fund schemes and arrangements being put in place to share and manage the risks.

The HFMA is active nationally and locally raising awareness of NHS finance and governance, influencing policy development and raising the skill base of those in financial management. We support NHS organisations and individuals in improving financial management and governance through periods of challenge and change as the new architecture of the NHS is established.

We hope the briefing will be helpful to a wide audience and would be delighted to hear your feedback. We would also welcome suggestions for ways we might further support you and the development of CCGs in the future.

Dawn Scrafield, chair of the HFMA Commissioning Faculty Technical Group

CONTENTS

Overview 2

Changing how services are delivered 2

The anticipated benefits 3

Measuring and reporting performance 5

The outcomes 8

Risk-sharing arrangements 8

Conclusion 9

Appendix: risks and mitigations 10

COVER PHOTOGRAPH: FOTOLIA

Overview

An important and high-profile component of clinical commissioning group (CCG) plans for 2014 onwards, the better care fund rides on a wave of expectation, national and local. Recognised as one way of delivering integration with services organised around the user, the use of pooled budgets should enable patients to experience a seamless service focused on their needs. As well as delivering more effective services, the fund may also facilitate more efficient services by crossing organisational boundaries.

Subject to approval by health and wellbeing boards (HWBs), completed plans for the operation of the fund were first submitted on 4 April 2014. With an intended value of £3.8bn on 1 April 2015, the total projected amount to be pooled is likely to give a fund of more than £5bn, with some areas having pooled close to or more than £100m and others their entire adult social care budget. At this point in the year, CCGs have submitted their plans and are working through the details of how those plans will be implemented in practical terms.

This briefing focuses on realising the benefits of integration in relation to service users, the NHS and social care. The importance of developing a clear commitment and understanding across all parties of what is involved in integration, what is being measured and how progress will be tracked is critical during 2014 in preparation for 'go live' on 1 April 2015. So CCGs and local authorities have spent time identifying and detailing the required indicators and associated baseline performance against which progress can be measured. But joint working is not new and all parties to the fund can learn from existing partnership arrangements and pooled budget arrangements in particular.

It is imperative that parties to the fund can show that the monies identified and subsequently pooled are used wisely and for their intended purpose – that the fund is performing against its objectives. To that end, the briefing will consider the measuring and reporting of performance to achieve the planned outcomes.

Effective partnership working also requires those involved to identify and share the associated risks and rewards. The briefing will also look at some of the arrangements in place in relation to existing integrated services, as well as those identified in fund plans.

Changing how services are delivered

Many areas see the better care fund as part of an existing agenda of integration and transformation of locally delivered services. The service user is the focus: 'What matters most to commissioners and providers are the improvements we make together for the benefit of patients and service users…'[1].

However, integration between health and local authorities is not new and many services have been delivered through partnership arrangements for a number of years on the basis of existing legislation[2].

Existing integrated services

Before considering the potential benefits identified in fund plans and how they might be realised, it is helpful to identify how the integration of health and social care services has already benefited service users.

In Birmingham, mental health and learning disability services have operated under a section 75 agreement since 2010/11, with a pooled budget of £298m in 2013/14. The city-wide single approach to commissioning is led by the joint commissioning team for mental health and learning disabilities. It commissions both NHS and social care services on behalf of the Birmingham Cross City CCG, Birmingham South Central CCG, Sandwell and West Birmingham CCG and Birmingham City Council.

This approach has helped health and social care organisations in Birmingham better understand the services delivered and the way users interact with them, as well as delivering around £51m of savings since it began. Operationally, this has been managed via an integrated commissioning board setting up the pooled budget to meet health and care needs. As a result, there is no discussion about which body pays, and better commissioning decisions can be made with joined-up solutions identified for service users. With the advent of the fund, the existing agreement underpinning the arrangement is now under review.

Meanwhile, in Thurrock, Essex, specific health and social care service users already have access to 'my account', providing them with online information and regular progress updates about the services they receive. The service aims to reduce the number of separate contacts with health and social care.

FOOTNOTES

[1] *Nottinghamshire's better care fund final plan: www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/bettercarefund/*

[2] *Section 75 of the NHS Act 2006 allows local authorities and NHS bodies to operate pooled budgets; section 256 of the NHS Act 2006 allows for a transfer of resource between health and local authorities but not a transfer of functions – a contribution is made to support specific local authority services without a delegation of health functions*

Building on existing integration

The money pooled through the fund is not new money and plans have involved 'rebadging' some existing ideas and services and aligning them to the objectives of the fund. In some areas, the advent of the fund has acted as an 'enabler' supporting the redesign of existing services to deliver greater benefits for service users.

In Liverpool, the city council and CCG are planning to redesign the care home market. Changes to the design and commissioning of specialist residential and nursing provision for those people with complex needs will be a focus over the coming months to ensure there is access to the right type of support in the event that placement in a care home is their best option. By taking a joint approach to an existing service, the council and the CCG aim to deliver a stable and financially sustainable care home sector in the future.

Where the fund builds on existing integration, it is important to identify how long the innovations generated by the fund will take to establish and how things will be different under the auspices of the fund going forwards.

Creating new opportunities

Some new models of care and service specifications will be in place for April 2015. In Wigan, the fund will provide investment in the provision of alternative 'housing with care', where appropriate facilitating the repatriation of people currently living in supported housing outside Wigan borough. As well as delivering care closer to home, the scheme should reduce placement costs for both the CCG and the local authority through a new integrated service model.

The anticipated benefits

Value for money

In terms of the operational and financial benefits for service users, health and social care, the fund brings an opportunity to look at the totality of expenditure and how high-quality and good-value services are provided – for example, by comparing total expenditure to patient/citizen outcomes.

The creation of the fund provides an opportunity to secure better value, as well as better care and it is therefore vital to understand and be able to demonstrate where benefits are anticipated and where the benefits realised are in addition to those that would have otherwise materialised. As stewards of public money, the accountable officer is responsible for ensuring that the CCG exercises its functions in a way that provides good value for money and complies with its obligations, including to ensure money is only spent on those things the CCG has the power to spend money on. The accountable officer must sign a statement at the year-end that, to the best of their abilities, their responsibilities have been discharged. Confidence in the set-up and operation of the fund will support the disclosure and the production of the annual report and accounts.

Practical examples

Our review of a sample of 18 plans found a high level of similarity in the overall benefits and planned improvements to care for patients and service users. The main benefits anticipated relate to improved outcomes for residents and patients through a seamless experience of services. Most are based on a prevention model, with patients and residents at the centre of changes to services.

Prevention model

More than half of plans described a 'prevention model' aimed in particular at improving the quality of life for frail elderly people and those with long-term conditions. The model involves tailoring services to individuals and ensuring they are delivered in the most appropriate settings. For many organisations, this will mean a community services-led approach. Some plans described local 'cluster' teams with wider community support; GPs are also expected to play a key role in coordinating care in some areas.

The benefits of this approach are to reduce the need for people to go into hospital or residential care and help people who do have to leave their homes to return home more quickly, through improved discharge arrangements and better support in their homes. Most plans focused on older people but some mentioned an aspiration to reduce health inequalities in their area and improve services for children and those accessing mental healthcare.

Patient-centred care

Many organisations' plans mentioned their goal to centre care on patients and residents. In practice, this means bringing services together into a single assessment so that health, social care and related services, such as housing and support for carers, are linked by professionals working together to

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Healthcare providers have a clear role in helping to realise the benefits associated with integration

meet jointly identified needs. Through this approach many organisations said they expected outcomes to be improved. Several organisations plan to ensure people have equitable access to care and services wherever they live, from better coordination of services to providing better access to information, help and advice. This expansion of community capacity is intended to help people meet their needs without having to use NHS and social care services. The plans also intend that services can be accessed through a single point, based on a single assessment of need, supported by an expansion of seven-day working.

Some organisations prioritised shared care planning between NHS and social care teams to minimise duplication. This may also involve personalising services by increasing uptake of personal social care and personal health budgets.

Improvements to the health and social care interface
Many aspects of the plans relate to improvements to ways of working between organisations involving a high degree of integration. Our review of plans found similarities in priorities to:

- Focus on maintaining independence in the community for as long as possible
- Reduce emergency admissions by fully assessing people before admitting to hospital
- Enhance hospital in-reach arrangements by community-based professionals
- Reduce delayed transfers of care out of hospital.

Several plans covered proposals for active case management, especially of the over-75s and those with long-term conditions, using risk assessment approaches to improve primary and community care support. Others described proposals to introduce seven-day-a-week community-based services across health, social care and GPs, including for those who require urgent assistance.

To support ambitions around early intervention and prevention work, several plans outlined integrated rehabilitation and reablement services, access to assistive technologies, equipment and housing adaptations and carers' support.
There were also mentions of a role for telecare. Several organisations set out how their plans would be supported by changes to the way that records and data are shared by organisations to allow better case management and earlier intervention or minimise duplication of assessment work.

Improvement to user experience
Several plans made it a priority to improve the patient and service user experience. This might be through developing processes to plan and support discharge from the first day of admission or for hospital clinicians to work, as part of a case management approach, to identify high-risk people through their contact with primary care.

The role of QIPP
In a recent HFMA survey, 64% of CCG finance directors said that existing quality, innovation, productivity and prevention (QIPP) schemes had been tied into fund plans[3]. In Coventry, urgent care and continuing healthcare QIPP schemes have been aligned to fund work streams. In other areas, developments identified in fund plans will build on existing QIPP schemes already in place by providing patients with better access to primary, community and mental health services.

The role of healthcare providers
Healthcare providers have a clear role in helping to realise the benefits associated with integration. Developing a broader range of community-based services means less money will be available to support contracts with NHS healthcare providers, particularly those in the acute sector. Contracts will undoubtedly look different in 2015/16. With monies released from routine commissioning, NHS providers of hospital-based services will need to reduce their operating costs as part of a financially sustainable health economy.

In theory, NHS providers will save money through reductions in delayed transfers of care, average length of stay and emergency admissions. Resources will transfer from existing acute contracts to support community services releasing savings, with only patients that cannot be treated in another setting being admitted to hospital.

In practical terms, this means providers will be able to reduce costs over time. However, providers must be involved to help deliver savings. In addition, transparency is needed as to how and where savings are realised, particularly those that relate to the health economy as a whole. Providers must know that the schemes outlined in fund plans are working and delivering the anticipated improvements. Going forward, detailed plans need to be jointly developed by local authorities, CCGs and providers, showing where money will be invested and needs to be released – explicitly identifying the likely impact on NHS providers.

FOOTNOTES

[3] *Taking the Temperature* HFMA, June 2014

Practical considerations include:

- The need to assess the realism and consistency of savings assumptions
- The need to refocus secondary care clinical services so that capacity and fixed costs are appropriately reduced
- The adoption of a staged approach to freeing up resources
- Consideration of the need for enabling funding for pump priming and covering potential double running costs as schemes are set up
- The impact on provider performance, notably in relation to the time patients wait in accident and emergency departments and pressure on referral to treatment times due to increased pressure on beds from acute admissions.

Savings will only be delivered by working with acute hospitals, going further than the sharing of plans but enabling providers to debate and influence the plans. For example, the potential impact of reorganising unplanned care across Birmingham is being considered by the unit of planning[4] involving the council, three CCGs and all the city's NHS healthcare providers. With NHS acute providers signed up to a reduction in bed capacity in the city, the potential operational and financial consequences are being worked through.

Measuring and reporting performance

Parties to the pooled fund, including the HWB, must be assured shared aims are being fulfilled. But it will only be possible to see the anticipated benefits and achievement of planned outcomes if performance is routinely measured and reported. The successful operation of the fund will therefore rely heavily on accurate and timely reporting of non-financial and financial information, ensuring everyone involved is clear about the information used and the performance planned and achieved.

Consequently, before the fund's 'go live' date, it may be helpful for CCGs and local authorities to review the existing requirements for reporting on pooled budget arrangements, as well as how the measurement and reporting of performance is working for existing integrated services, for the parties involved and the wider health economy.

Existing requirements

In-year reporting of the performance to the parties to the pooled budget agreement must be undertaken by the host on a quarterly basis[5]. The regulations require the host (through a nominated 'pool manager') to provide quarterly details of income to and expenditure from the pooled fund as well as '…other information by which the partners can monitor the effectiveness of the pooled fund arrangements'.

In terms of the fund, the latter may include performance against the identified metrics but will depend on what is specified in the underlying agreement.

Existing arrangements

Here, it is important to consider where performance measurement is working well for existing partnership arrangements in general and integrated schemes in particular. This could include a review of the service specifications and associated performance metrics of schemes operating under section 256 arrangements in 2014/15[6].

As noted above, the integration of mental health and adult learning disability services in Birmingham via a section 75 pooled budget agreement is well established.

Although the organisations are coming to the end of the existing agreement (which is now under review), the local authority has consistently monitored performance in relation to learning disability services with some success.

The experience here will inform the agreement underpinning the fund, particularly in terms of the need for 'hard specifics' in performance monitoring from the outset.

Although a number of key metrics are already tracked in relation to mental health, learning disability and acute services, the supporting data is not always sufficiently granular to enable changes in the metrics overall to be readily understood.

Focus is now on improving and linking this underlying data – for example, the number of patients discharged by each acute provider in the city into nursing homes with the length of stay for those patients once placed in a nursing home highlighting variations in outcomes.

In Leeds, a dashboard approach has been established to measure performance in key areas over time based on a single, shared database drawing information from the secondary uses

Savings will only be delivered by working with acute hospitals, going further than the sharing of plans but enabling providers to debate plans

FOOTNOTES

[4] A unit of planning is a grouping of NHS and social care commissioners and providers who work together to produce a strategic plan for their local health economy with the aim of delivering clinical improvements. The size, format and approach of each unit will depend on local arrangements but all relevant parties must be involved. No units of planning should overlap and the whole population must be covered by a unit of planning

[5] Statutory instrument 2000 number 617 section 7 paragraph 4(b)

[6] Currently, funds are transferred to local authorities according to section 256 of the NHS Act 2006

system (SUS), adult social care, community and GP practices. The dashboards produced enable the Integrated Health and Social Care Board to track metric performance, such as bed use and emergency admissions to hospital.

National and local metrics

In fund plans, CCGs and local authorities were required to incorporate the metrics to measure performance, calculate an appropriate baseline and anticipate the extent to which performance against the identified metrics is likely to improve over time. The metrics aim to:

- Help people stay at home (national measures)
- Drive specific improvements (local measures).

NHS England encouraged locally set ambitions to be identified against each metric, with CCGs asked to achieve 'statistically significant improvements' against baselines. In order to assess performance against plan, all parties need to understand what is being measured and when.

National metrics

Going forwards, fund performance will be measured against the following national metrics:

- **Admissions of older people (aged 65 or above) to residential and care homes** This covers council-supported admissions as this is the only nationally available routine data collection. The data is published annually.
- **Effectiveness of reablement** This metric is used to analyse the proportion of older people (65 and over) who are still at home (settled and independent) 91 days after discharge from hospital into rehabilitation services. Records will be needed of the number of relevant people offered reablement and rehabilitation services. The data is also published annually.
- **Delayed transfers of care** This metric takes account of all delayed transfers of care from all hospitals for all adults and is defined as the average delayed transfers of care per 100,000 population (attributable to either NHS, social care or both) per month. The data is published monthly.
- **Total emergency admissions** This metric is based on the resident population of the relevant local authority and is the sole indicator underpinning the pay for performance element of the fund. A reduction in all general and acute emergency admissions is required and should reflect improvements in the overall quality and effectiveness of the health and care system. The metric calculation[7] uses data that is routinely collected and available monthly.
- **Patient/service user experience** In the absence of a nationally determined metric (one is under development by NHS England), CCGs and local authorities could identify, agree and use a locally available metric to measure user experience.

From the analysis of a sample of 15 published plans, the following can be concluded:

- Planned changes in national metrics vary from plan to plan. The biggest improvement in our sample is in the delayed transfer of care metric; the metric with the lowest planned improvement is in the proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement/rehabilitation services.
- Planned changes, in many cases, do not represent significant improvement at the 95% confidence level using the NHS England ready reckoner tool[8].
- In the absence of a national metric, patient experience is not being measured, as plans show that all of the councils and CCGs in our sample are waiting for the national metric to be available.

Local metrics

We reviewed a sample of plans to analyse which local metrics had been included. National fund guidance requires plans to include a metric either from a nationally set list or an appropriate locally set metric. Of our sample of 15, nine selected a metric from the national list and six chose their own local metric. One plan identified two local metrics, both selected from the national list.

National planning guidance specifies nine metrics, taken from the NHS Outcomes Framework, Adult Social Care Outcomes Framework and the Public Health Outcomes Framework. The metrics chosen in our sample of plans are shown in the table on page 7. In particular, the fund plan for Leeds identifies three local metrics:

- The estimated diagnosis rate for dementia given the focus on supporting people with it
- The total number of bed days spent in care/residential home facilities, looking at a combination of residents admitted to care/residential homes and their lengths of stay
- A measure relating to bed day use across the health and social care system (being developed).

Reporting performance

As noted above, in-year reporting is governed by the requirements of SI 2000/617, specifically section 7 paragraph 4(b). In practical terms, this means all parties to the fund will need to consider

FOOTNOTES

[7] *Better Care Fund Revised Technical Guidance*, NHS England, July 2014

[8] www.england.nhs.uk/wp-content/uploads/2014/03/bcf-read-reckoner.xlsx (accessed 2 July 2014)

[9] Department of Health Emergency Care Intensive Support Team

the clear and open reporting of non-financial and financial information in terms of:

- The monitoring and reporting required by the HWB and any subcommittee established to operate the fund and provide day-to-day leadership – for example, the better care fund board in Birmingham; the integrated care and support group in Solihull; the better care fund commissioning group in Slough; the integrated commissioning executive in Leeds
- The monitoring and reporting required by all parties to the fund, both in-year and at year-end
- The timing of reports, particularly where the fund reporting timetable may require reporting to the CCG (and potentially in public at a meeting of the governing body) before reporting internally within the local authority – for example, expenditure related to the disabled facilities grant
- The reflection of the fund in the risk register (this should reflect the key associated risks including performance reporting if it is undertaken by another organisation) – to be routinely considered by the audit committee in the first instance
- For CCGs, the routine review of the quality of services delivered by the quality committee.

The CCG's governing body will also need to be familiar with:

- The level of contribution made to the fund
- What has been spent at a point in time
- What has been delivered
- How the fund is performing in overall terms.

It is also important to discuss and agree a local approach to financial reporting in relation to:

- The fund as a whole
- Individual schemes
- In-year reporting of the cumulative/year-to-date position
- The year-end forecast
- The point at which contributions to, expenditure on and subsequent variances are recognised in relation to:
  - The budget for a whole service where it is part of the fund
  - Contributions made to larger budgets from the fund – for example, in support of nursing or residential homes; if the larger budget overspends, does the fund take a hit?

All these issues need to be thought through and the local 'operating rules' documented in the fund agreement. In relation to mental health and learning disabilities services in Birmingham, NHS and local authority accountants came together on financial reporting and management, although the statutory bodies continue to report separately.

Benchmarking performance

At this point in time, it is too early to identify the standards against which fund performances will ultimately by benchmarked. In the absence of knowing what good looks like, it will be important for CCGs to articulate their own views to patients and service users and the wider public, the HWB, the council of members and in its annual report and accounts.

Metric baselines will also need to be adjusted as performance improves. For example, if by April 2015 performance in terms of avoidable emergency admissions is considerably better than anticipated, the baseline is likely to need to be revised downwards.

Of our sample of 15 plans, nine selected a metric from the national list and six chose their own local metric

METRICS CHOSEN FOR OUR SAMPLE

Local metrics selected from the national list	Number of plans
Estimated diagnosis rate for people with dementia	3
Injuries due to falls in people aged 65 and over	2
Social care quality of life	2
Proportion of people feeling supported to manage their (long-term) condition	2
Locally selected indicators	
Emergency admissions due to injury, poisoning and certain consequences of external causes	1
Emergency readmissions within 30 days of discharge from hospital	1
Maximum length of stay of sick general emergency admissions using the ECIST[9] model	1
Older people discharged from hospital into reablement/rehabilitation services as a percentage of the total number of people (aged 65 and over) discharged from hospitals	1
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes	1
Average EQ-5D (health related quality of life) score for people reporting one or more long-term conditions	1

There is a need to demonstrate outcomes on a regular basis to ensure continued engagement with the fund from those involved

The outcomes

There is a need to show outcomes regularly to ensure continued engagement with the fund from all those involved, including GPs, primary and secondary care clinicians, patients and the public. However, measuring outcomes in general and benefits in particular is very difficult – if, say, the number of occupied bed days reduces, how much of the change is directly linked to the fund?

It is important to recognise that few things happen in isolation and developing a clear link between cause and effect is particularly difficult in healthcare. In Leeds, this has been approached at a macro level. Rather than attempting to isolate cause and effect for individual fund schemes, it is recognised that multiple schemes are likely to impact on overall performance against national metrics. Performance is tracked on a monthly basis – but results may not be seen for some time.

To bolster the likelihood that benefits are delivered, some CCGs have used the 2014/15 contract negotiations to support fund commitments alongside outcome ambitions, NHS Constitution requirements and QIPP schemes. A core requirement of the NHS provider 2014/15 contracts in Leeds is to work with commissioners to facilitate seven-day-working requirements.

Intended outcomes

The fund aims to support an improvement in the quality of services delivered to patients by:

- Delivering better services to older and disabled people who have multiple and complex needs
- Keeping people out of hospital
- Avoiding long hospital stays.

Tangible progress against the metrics in 2014/15 and 2015/16 will demonstrate whether this has been achieved. By understanding the intended outcomes and performance against them, corrective and timely action can be taken if schemes fail to deliver the anticipated benefits. This will be best supported by flexibility in the system so that funds can be moved depending on the performance and outcomes of schemes.

Payment for performance

A total of £1bn has been set aside for the payment for performance element of the better care fund. Following an announcement of 5 July[10], this has now been tied solely to the achievement of a reduction in emergency admissions.

Of the performance monies available, HWBs will need to propose their own 'pot' based on a reduction of emergency admissions of at least 3.5%. If this target is not achieved, the performance money will be used to support NHS services to pay for continuing acute hospital admissions. The balance of the performance allocation will be available immediately, to be spent on NHS-commissioned out-of-hospital services. Detailed workings are to be confirmed.

Failure

At present, NHS England guidance suggests that if national and local targets are missed and local arrangements fail to deliver the projected benefits, the local health economy will be required to develop a recovery plan – funded locally. The recovery plan and performance against it will be subject to peer review by NHS England and local government. Persistent failure may lead to a loss of local autonomy, with direct commissioning being transferred to NHS England.

Seeking continuous assurance

Those charged with governance[11] in each statutory organisation will seek continuous assurance that things are working as they should. In practical terms, this may take the form of consideration of assurances both internal and external to the organisation, the robustness of the data underlying those assurances and the implication of the results on whether or not the objective of the assurance is being met. For example, a CCG's audit committee may consider performance against the national metrics in conjunction with expected expenditure over the same period alongside expected outcomes.

This review might be supported by the consideration of the processes involved in collecting the data used to calculate one of the metrics – for example, the average delayed transfers of care per 100,000 of the population each month.

Risk-sharing arrangements

Identifying key risks and mitigations

Key risks associated with the fund and a number of actions that may be taken to mitigate those risks are outlined in the appendix on page 11. The list is not exhaustive and is drawn from a sample of plans submitted in April and the better care fund workshop held by the West Midlands Branch of the HFMA in May 2014.

FOOTNOTES

[10] www.gov.uk/government/news/better-care-plans-to-provide-dignity-independence-and-reduce-ae-admissions

[11] This is normally the CCG's audit committee

For example, to mitigate against a lack of engagement across Birmingham and based on its experience of pooling mental health budgets (where each of the partners has managed their own risks – the arrangements detailed in the underpinning agreement), the local authority and NHS bodies have recognised their plans are best supported by a formal sub-committee of the HWB. The Birmingham adult unplanned care integration board was established in April 2014 to oversee delivery of fund plans and collectively manage the operational challenges during the period of transformational change.

The membership consists of chief executive officers or an immediate executive nominee from each major commissioner and provider organisation in the city. This board will report into both the chief executive officer forum and the HWB and will require delegated powers from the city council and CCG governing bodies to operate effectively going forward.

The partners are thinking through the pathways and treatments for patients and service users, many of whom need care over a whole lifetime. This means they have to think through all the possible health and care needs that may be allied to their mental health issue or learning disability.

Sharing risks and benefits

Having considered the nature of risks involved, it is important to look at the detail of those that are shared and those that are risks to individual organisations. Risk-sharing arrangements for the fund will therefore need to cover both:

- Risks to individual organisations – in particular, the potential impact on provider viability of service changes
- Risks to the wider health economy.

In Leeds, one way that this has been approached is through pump-priming fund schemes in 2014/15, thereby ring-fencing money for 2015/16 when it becomes part of the pooled budget. As and when a scheme delivers savings, they will be fed back into the fund for future reinvestment.

A contingency amount has also been included that will, for example, allow any increase in expenditure on non-elective care to be funded in the event that fund schemes fail to deliver the anticipated fall in non-emergency admissions.

In Birmingham, where the health economy as a whole faces significant financial challenges and a continual growth in non-elective admissions, two risk-sharing arrangements are likely – between two of the city's CCGs and the local authority and the third CCG and the local authority.

In the first arrangement, any surpluses or deficits would be shared on a capitated basis. In addition, there is recognition that the future section 75 agreement will need to detail the specific interventions covered by the fund, mapping out the resource against each intervention, the anticipated outcome and the responsible organisation. At the same time, the case for change is being developed alongside significant public engagement with a view to reducing the number of acute beds across the city.

Over the coming months, it may be helpful if the audit committee regularly reviews a risk management framework (covering clinical, operational and financial risks). It may also be helpful to consider the use of outcomes-based contracts supported by capitated payments, outcome-based payments or gain share arrangements.

Conclusion

A policy of integrated working between health and social care must be the focus for the coming months. Going forwards, 'better' must mean services that are both of better quality and better value, and are sustainable and efficient. Finance staff have a vital role here. Now is the time to review what is being achieved by existing section 75 arrangements, as well as considering how to generate a shared confidence that investments and disinvestments are having and will have the desired effect.

While the fund plans focus on the local health economy in its entirety, it is important to recognise that not many things happen in isolation. The financial stability of some health economies and individual NHS providers will be affected by the implementation of the fund and the potential impact must be considered in the widest sense.

Integration is the right thing to do and for finance staff this means understanding and sometimes challenging how the money works and will work in the local system, particularly where financial challenges are faced. ■

Those charged with governance in each statutory organisation will seek continuous assurance that things are working as they should

Appendix

APPENDIX: RISKS AND MITIGATIONS

Risk	Mitigation
Lack of engagement internally and externally, including with primary care	Early engagement of representatives from relevant NHS and local authority bodies, including NHS England; securing effective patient representation by making use of local authority experts by experience, existing patient groups, foundation trust members and the council of governors; developing a comprehensive communication and engagement plan
Lack of agreement in relation to priorities and integration of services	Provide a stable platform from which stakeholders can be fully informed; seek to reflect stakeholder views into design and implementation discussions
The savings and efficiencies needed to deliver transformational change may not materialise	Plans are fully costed and likely efficiencies estimated; close monitoring of progress post implementation
The absence of clear arrangements for under- or over-delivery	Clear local processes set out in signed agreement, including that for disagreement resolution
Insufficiently detailed signed agreement	Rules on data and performance management agreed up front
The speed of change required	Undertaking patient-based clinical audit providing detailed evidence to support plans; grasping a 'big bang' approach to changes in services, avoiding double-running costs
Clarity of roles and responsibilities	Who is allowed to decide what and where delegated authority is best placed; defined process for decision-making with appropriate schemes of delegation
The lack of detailed baseline data and the need to rely on current assumptions may mean that financial targets are unachievable	Proposals are based on all available data and are refined over time
Failure to deliver change on a sustainable basis	Securing effective patient representation by making use of local authority experts by experience, existing patient groups, foundation trust members and the council of governors; development of detailed business cases and service specifications to support proposals; flexibility to move funds as needed
Financial failure of an NHS provider	Commitment of organisations to work together and understand whole-system spend and saving requirements and monitor change; plans developed as to how beds will be closed without destabilising local acute providers

Risk	Mitigation
Ineffective governance arrangements	Thinking through the necessary governance arrangements, including: ● The terms of reference of the HWB ● The appropriateness of a formal committee to the HWB ● Any amendments that might be needed to the business rules of the HWB, CCG and local authority
Failure to understand financial flows particularly in relation to savings, reinvestment, benefits and risks	Commitment of organisations to work together and understand whole-system spend and saving requirements; financial impact on individual organisations as well as for the health economy as a whole
Monitoring of work carried out under the fund will need to be resourced to be effective	Resources discussed and jointly agreed/provided by health and social care
Existing workforce is unable to deliver the projects needed to make the vision a reality	Investment in infrastructure and workforce to support wider organisational development
Reputational damage of failure to deliver	Development of proposals involves rigorous consultation and engagement, review and scrutiny
Impact of the Care Act 2014 results in significant cost pressures that cannot currently be quantified	Plans developed for the introduction of the Care Act; senior officer appointed; impact monitored

Appendix

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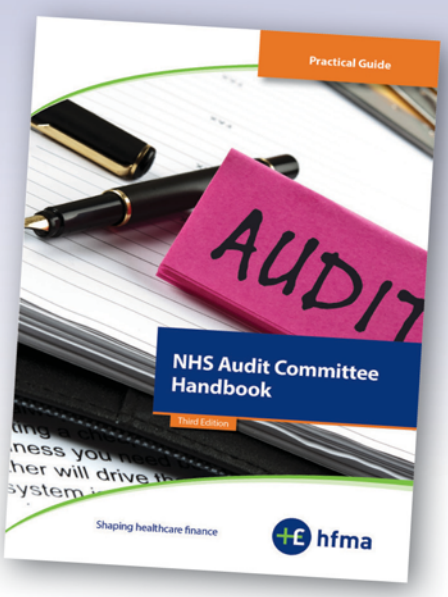

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